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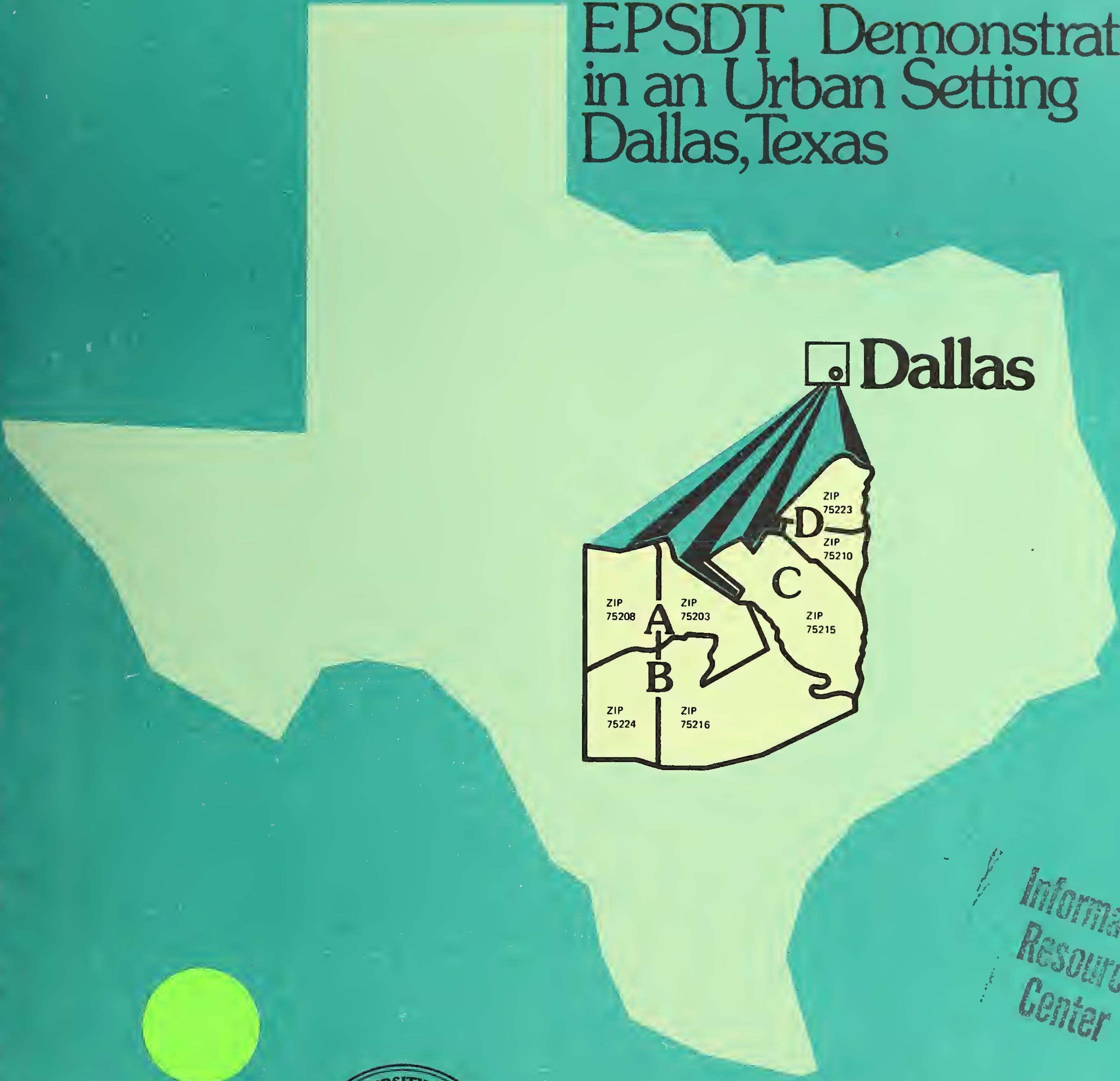
EVALUATION REPORT PHASE 3
Feb 1976 - June 1977

EPSDT Demonstration in an Urban Setting Dallas, Texas



Information Resource Center

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NUMBER OF DAYS TO INITIATION OF TREATMENT FROM THE DATE OF REQUEST FOR SERVICES*

	Total Problems Treated	Days 0-60	61-120	121-150	151-180	181-210	211-240	241-270	271-300	301+
1. Dallas Project	418	68%	85%	91.6%	96%	97.2%	98%			
2. Nine State Study	3431	72%	85.2%	91.3%	94.4%	96.8%	98%	99%	99.5%	100%
i. Dental Rx		62.4%	77.3%	85.9%	90.7%	94.2%	96%	98%	99%	
ii. Hearing Rx		62.1%	79.8%	87.9%	91.1%	93.5%	95.2%	96.8%	98.4%	
iii. Hematocrit Rx		88.6%	93.8%	96.2%	98.6%	99.5%				
iv. Vision Rx		65%	81.8%	89.2%	93.1%	94.7%	97.5%	98.8%	98.9%	
v. Other Rx		79%	90%	95%	97%	98%	99%			

Recommendation: 1. We should proceed with our recommendation of 75% within 120 days and 90% within 180 days.

a. This should present no problem if one notes that using the 91-120 days frame on the chart would effect treatment at a 85% (Dallas) and 85.2% (Nine State) rate from the date of request for services.

b. The 151-180 day frame on the chart would effect initiation of treatment at a 96% (Dallas) and a 94.4% (Nine State) rate from the date of request for services.

* This chart is derived from information obtained from the Health Services Research Institute (HSRI) of the University of Texas at San Antonio. The baseline information is attached. The information from HSRI reflected the time it took to initiate treatment once a positive screening finding was made. Essentially we have added 60 days to HSRI time frames to allow for the time from the date of request for services until the date of screening. We feel that the information is relatively hard. The nine State data is felt to be representative of the nation.

NUMBER OF DAYS TO TREATMENT FROM THE DATE OF SCREENING FOR THOSE RECEIVING TREATMENT

	Total Problems Treated	Days 0-30	31-60	61-90	91-120	121-150	151-180	181-210	211-240	241+
1. Dallas Project	418	68%	85%	91.6%	96%	97.2%	98%	%	%	
2. Nine State Study	3431	72%	85.2%	91.3%	94.4%	96.8%	98%	99%	99.5%	100%
i. Dental Rx		62.4%	77.3%	85.9%	90.7%	94.2%	96%	98%	99%	
ii. Hearing Rx		62.1%	79.8%	87.9%	91.1%	93.5%	95.2%	96.8%	98.4%	
iii. Hematocrit Rx		88.6%	93.8%	96.2%	98.6%	99.5%				
iv. Vision Rx		65%	81.8%	89.2%	93.1%	94.7%	97.5%	98.8%	98.9%	
v. Other Rx		79%	90%	95%	97%	98%	99%			

1. The chart shows the length of time it took in 1 and 2 for problems that had been identified in screening to reach treatment.
   a. HSRI says that the time from "request" to screening in the Dallas Project ranged from 5-28 days - the mean being 17 days.
   b. Generally, HSRI felt that 30 days from "request" to screening should generally be sufficient.
   c. Therefore, one might add 30 days to the "Days" columns in order to derive a reasonable "request" to "initial treatment" time frame.

2. HSRI notes that the most serious problems are treated most quickly.

3. In the Nine State Study, the following number of cases did not get to treatment - 1694.
   They were, by category:
   a. 100-waiting list
   b. 181-repeated appointment failure
   c. 261-refused treatment
   d. 82-no longer apparent
   e. 72-no longer eligible
   f. 998-unknown/undocumented

4. a. In 2 above, only a. (100), would be added to the number of problems on the chart for which the State would be responsible.
   b. b.-e. would be thrown out of the sample.
   c. f. would no longer be undocumented and would be expected to fall into the same time frames as the "problems" (3431) in 3 in the chart.

Summary: a. If we take the 61-90 day frame and add 30 days for "request" to "screening" we see that for Dallas and the nine States, 91.6% and 91.3% reach treatment within 120 days from request for services.
   b. If we allow 60 days for "request" to "screening" then the above is true within 150 days.
   c. Our current proposal calls for 75% within 120 days. This should present no problem if one notes that using the 31-60 days frame on the chart would allow 60 days from request to treatment at a 85% (Dallas) and 85.2% (nine State) success rate. This would allow approximately a 10% "error" rate administratively.
   d. c. above is defensible but allows little "error" flexibility. We should allow 60 days for "request" to "screening" in our calculations.

Recommendation: We should proceed with our recommendation of 75% within 120 days and 90% within 180 days. Allowing 60 days for "request" to "screening" would place us in the 91-120 day time frame (120+60=180) at a 96% and 94.4% success rate re: Dallas and the Nine State Study.

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THIRD EVALUATION REPORT

HCFA/DHEW Demonstration Project

EPSDT IN AN URBAN SETTING - DALLAS, TEXAS

Periods Covered:
Start-up Period: July 1, 1975 - January 31, 1976 (7 months)
Cumulative Data: February 1, 1976 - June 30, 1977 (17 Months)
Current Test Period: January 1, 1977 - June 30, 1977 (6 Months)

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TABLE OF CONTENTS

Page

SUMMARY i

- Project Setting i
- Current Activities
  - General
  - Case Finding (outreach) Activities i
    - Use of Multiple Screening Sites (Neighborhood Clinics)
    - Use of Specialized Screening Clinics (for Young Adults) iv
  - Case Monitoring (follow-up) Activities vi
    - Introduction of a Distinct Case Monitoring System
  - General Project EPSDT Performance Results x

CHAPTER I - INTRODUCTION 1

- Background 1
  - Case Finding 2
  - Case Monitoring 3
- Project Structure
- Major Project Demonstration Activities 4
  - Case Finding 5
  - Case Monitoring
  - Schematic - Case Finding Project Variables 6
  - Schematic - Case Monitoring Project Variables 7
- Schedule of Evaluation Reports 8

CHAPTER II - CASE FINDING 9

- Test Objectives 9
- Schema - January 1977 - June 1977
- Program Eligibles
- Evaluation - Effectiveness Measurement Rates 10
- Evaluation of Variables 11
  - Use of Multiple Screening Sites (Neighborhood Clinics)
    - Antecedents
    - Objective: Multiple Screening Sites 12
    - Evaluation
    - Program Implementation
      - Location, Number and Accessibility of Screening Sites
      - Schedule of Neighborhood Clinics 14
      - Organizational Arrangements
      - Outreach and Follow-up Techniques

Page

Screening 15
Clinic Staffing
Management and Process
Tests and Measurements Utilized
Factors Influencing the Results Other than Major Factors being Tested 17
Results 19
Conclusion 25
Use of Specialized Screening Clinics for Young Adults (13-21) 26
Antecedents
Objectives - Young Adult Clinics 27
Evaluation
Program Implementation
Young Adult Clinic - Program Content
Outreach Methods 28
EPSDT Screening Clinic Scheduling 29
Transportation 30
Excused School Absences
Results
Conclusion 31

Use of Combined Case Finders/Case Monitors 33
Antecedents
Distribution of Time between Functions 34
Test Objectives
Evaluation 35
Technique and Skill Levels 36
Results
Combined Case Finders/Monitors - Different Skill Levels (Sector A vs B - Same Time Period) 36
Combined Case Finders/Monitors - Separate Case Finders and Case Monitors (Sectors A/B vs A/B - Different Time Periods) 39
Combined Case Finder/Monitor - Different Techniques Sector A vs D - Same Time Period 42

CHAPTER III - CASE MONITORING 46

Test Objectives 46
Schema - January 1977 - June 1977
Case Monitoring Work Load 47
Health Problems
Immunizations 48
Distribution of Case Monitoring Work Effort
Evaluation - Effectiveness of Measurement Rates
Evaluation of Variables 49
Introduction of a Distinct Case Monitoring System
Antecedents
The Test 52

Page

Implementation 53
Impact of a Distinct Case Monitoring System
Discussion
Results
Impact of Limited and Extended Case Monitoring 54
Discussion
Results
Conclusion 55
Use of Combined Case Finder/Monitors - Different Case Monitoring Techniques 56
Use of Combined Case Finder/Monitors vs Separate Case Monitors
Antecedents
The Test
Evaluation - Effectiveness of Measurement Rates 57
Results
Conclusion 58

CHAPTER IV - COSTS 59

Rates 59
Case Finding
Case Monitoring
Reporting Cost Data 60
Direct Costs
Indirect Costs
Overall Costs
Total Project Operational Costs
Unadjusted Cost Distribution by Functional Category 61
Adjusted Cost Distribution by Functional Category
Case Finding Costs 62
Case Monitoring Costs 63
Screening Costs 64
Summary of Performance Unit Costs and Related Rates by Sector 66

Exhibits 67

EPSDT Forms Used by Project 74

SUMMARY

1. Project Setting

The Dallas project "EPSDT in an Urban Setting" was approved in July 1975 as a three-year demonstration by the Social and Rehabilitation Service,[1] DHEW, under Section 1115 of the Social Security Act.

The project was established to develop innovative and effective outreach methods to increase participation in the EPSDT program and follow-up methods which would increase the degree to which children with problems found in screening receive and complete treatment.

The existing mode for the delivery of EPSDT in the Dallas area is with the Department of Public Welfare[2] exercising overall program responsibility, as well as outreach (case finding) and follow-up (case monitoring). The Texas Department of Public Welfare has contracted with the Texas Department of Health for the accomplishment of the screening. Children with problems found in screening are usually referred to the private sector of health for diagnosis and treatment.

Two previous reports have been issued on this project: Phase I, covering the start-up phase from July 1975 to January 1976, and the demonstration period of February 1976 to June 1976, dated November 15, 1976; and Phase II, covering the demonstration period of February 1, 1976 to December 31, 1976, dated May 15, 1977.

2. Current Activities

a. General

There were eight activities tested in this report period; five in outreach (case finding) and three in follow-up (case monitoring). Three of these eight activities produced results which are of significance and have potentially broad application. These are capsulized for this summary and are immediately following; two are case finding activities and the other case monitoring. Details on these and the other five activities are contained in the body of the report.

b. Case Finding (Improved Program Participation) Activities

(1) Use of Multiple Screening Sites (Neighborhood clinics)

(a) Phase I

The initial thrust in case finding in the project was to greatly intensify personal contact with the client over that employed in the regular program. This intensified personal contact took the form of home visits for all program contacts. The result of this first case finding effort was a disappointing annualized client participation rate of approximately 40% as an average for all three test sectors (A, B, and C). This was virtually the same rate as the regular Department of Public Welfare ongoing program was achieving in Sector D (the control/comparison sector) with a sequenced approach of, first, a letter (no less than three to achieve a response), secondly, telephone contact to those who did not respond to the letter and, thirdly, personal in-the-home contact to those not successfully recruited by the first two efforts.

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[1] Redesignated the Health Care Financing Administration in February 1977

[2] Redesignated the Department of Human Resources in September 1977

Although project client contact and initial agreement to participate in the program was high (86% of those contacted), repeated screening appointment failures by many clients resulted in only 51% of appointments kept after three efforts to achieve a successful appointment. It was mainly this low rate of kept appointments that brought about the low participation rate. This suggests that levels of program participation achieved by normally employed case finding efforts might be much lower than generally expected. It further implies that uncustomary, innovative, and vigorous methods will be required to achieve participation rates in excess of 50% - 60%.

(b) Phase II - The Current Phase

1 The Test

The current test in this report period was to determine whether improving the accessibility of the screening services would materially improve the participation rate.

The test was intended to maintain constant the already established highly personal in-home outreach technique supported by DPW contracted transportation for client services, and superimpose six additional neighborhood EPSDT screening sites, using transportable equipment, donated community facilities, and National Council of Jewish Women volunteers to assist with the screening. In effect, this reduced the average distance from the clients' homes to the screening site in the test sector (C) from 55 city blocks (2.5 miles) to eight - ten city blocks (.4 to .5 miles).

A part-time project EPSDT screening team was established to operate the additional sites.

2 The Result

The following results were achieved in the six-month period of this test.

The appointment kept rate for one appointment increased from 33.5%, when only one screening site was serving Sector C, to 54% and the appointment kept rate after three appointment efforts increased from 51% to 74.2%.

The overall projected annualized client participation rate increased from 51% to 60% (Sector C).

The true level of participation through this combination of outreach, transportation and accessible screening sites is expected to be more in the area of 65% - 70% when tested over a longer period of time than six months, since the short range rate of appointments made, of those contacted, had reached 98% and the rate of screening appointments kept had reached 74%.

3 Discussion

Apart from these significant statistical indicators of the importance of readily accessible screening sites, the case workers reported a highly favorable reaction by the mothers to the more convenient locations. The neighborhood identification of the screening clinics and the closeness to home was a distinct advantage in "selling" the program. The client may have perceived the neighborhood clinic as a significantly reduced commitment of time to the total activity of screening, which to her is preparation time, travel time, waiting time, screening time, return travel time, etc. In the earlier single screening site (Phase I), when the average distance from home to screening site was 2.5 miles, many mothers may have perceived the total commitment of time to the process as being from three to five hours. In this Phase (II), many may have perceived their total investment of time to the screening process as being in the range of two to three hours.

In this phase, the number of clients walking to the clinic increased by 80% (from 18.4% to 33.2%).

It is not possible to state that these demonstrated increases in program participation were due solely to the increased accessibility of the neighborhood screening sites. Though the main components of the case finding effort, such as the in-home/face-to-face client contact technique and the skill level of the case worker were held constant during Phase I and II (Sector C), other variables that needed to be held constant shifted sufficiently in emphasis as to somewhat dilute the purity of the results. These factors, as discussed in greater detail in the body of this report, were transportation where, in the current period (Phase II), a more responsive and less time consuming service was provided; management and structure, where single management of the total activities involved, i.e., outreach, transportation, screening, may have offered some efficiencies in performance over Phase I; and health education, where a more intensive problem related health explanation was provided the mother.

Another and programmatically better interpretation of the results would be to state that a "package of case finding methods", consisting of the in-home client contact by community indigenous aides, offering clients an EPSDT program wherein screening sites would be neighborhood identified (generally no more than an average of ten city blocks from home), and to which transportation would also be provided so as to assure that the whole process would not consume more than two or three hours, will produce rates of screening appointments kept in the order of 74% and client program participation rates in the order of 60% - 70%.[1]

4 Conclusion

Readily accessible and convenient screening services have a significantly beneficial impact on client participation in the EPSDT program.

Increased program screening costs for replicating the neighborhood screening clinic approach should be minimal in urban centers in which screening teams already operate out of several established sites. Appropriate screening equipment and supplies are generally readily transportable in private cars, small recreational vans, or panel trucks. Donated space for clinic sites was used in all instances in this project activity and community organizations were generally anxious to cooperate. Community volunteer organizations were eager to participate in providing supplemental staff to the clinic. If, as in Dallas, the screening teams already operate out of a limited number of sites, additional sites increase the total of staff travel time and travel costs to only a nominal extent.

(2) Use of Specialized Screening Clinics for Young Adults (13-21)

(a) Antecedents

The young adult component of the EPSDT program eligibles has only participated in the program, since its inception, at about one-third the rate of the younger age group.

(b) The Test

The Dallas project in this report period tested the use of specially designated and restructured ongoing EPSDT screening clinics to serve specifically the needs of young adults as a means to increase their participation in the program.

These clinics were to offer an extensive program of additional services of concern to young adults. This included the availability of health education and counseling services in alcoholism, drugs, family planning, birth control, teenage pregnancies, veneral disease, job opportunities, etc. These services were to be provided by interested and cooperative community organizations with special interests in these fields.

The initial concept for the test included an outreach effort being conducted through the schools primarily associated with the young eligibles from the specific project sectors. This approach also envisioned the use of young adult advisory groups and councils within each school with a high density of eligibles to assist in the promotion of the Young Adult Clinics and the EPSDT program. This approach was ruled out during the pre-test phase because no means could be found to avoid "labeling" the welfare children as such if they participated in EPSDT in the school context.

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[1] This is an analysis of only one of five subsystems of an EPSDT program. A presumption exists that there is an absolute linkage to diagnosis and treatment when problems are identified in the screening process.

(c) Results

The number of young adults participating in the test were so limited (157) as to preclude any significant impact on the total eligible population. Notwithstanding the "show for screening" or "kept appointment" rate for up to three appointments was quite favorable (59%). The rate of shows for screen increased with each clinic, which was indicative of its growing acceptance.

An assessment of the attitudes of the participating agencies toward this mode of EPSDT for young adults was generally favorable and would have been more so if attendance could have been greater.

(d) Conclusion

In a subjective sense, it should be concluded that the Young Adult Clinic had a beneficial impact on the young people it had contact with, but that the expense, measured in terms of manhours committed by the participating agencies and project personnel, was not justified by the number of clients involved.

(e) Additional Consideration of Importance

This result was, in many ways, predetermined by the pre-test decision to disassociate the case finding aspect of this activity from the schools.

The overriding concern about possibly labeling the young adults among their peers in the school environment as "welfare cases", has been encountered by this Institute in a large number of jurisdictions and, seemingly, universally precludes the school associated EPSDT model from further consideration. This would be unfortunate if allowed to persist for the school associated EPSDT model, as a voluntary mode, offers perhaps the greatest potential of any for low cost, high rates of participation by EPSDT eligibles ages 13 - 21 (ages6 - 12).

There are instances, however, where the school model, in one form or another has worked without the risk of labeling. Two known instances have been in EPSDT projects funded by SRS, DHEW, i.e., Cuba, New Mexico and Contra Costa, California. In these situations waivers for participation of the non-AFDC components of the respective target populations were an integral element of the project. In these instances the Federal project funds paid for the participation of the non-eligible group and the State/Federal Medicaid match funds paid for the AFDC or categorical eligibles. The inclusion of all children as eligibles avoids the issue of "labeling".

The point is that the issue can be avoided and the vital school model utilized if an alternative is developed which provides an "umbrella" that precludes the assumption that a participant in the program was necessarily a welfare recipient. An alternative that fits this criteria is to make the program available to all children in the school, but charge for the screen at the State Medicaid fee rate. Payment for non-Medicaid eligible children could be on a fixed or scaled fee, based upon the ability of the parent to pay. This program should contain provisions for cash payment or insurance payment (to include Medicaid). Children whose parents opt to participate in this program could not, therefore, be labeled as welfare clients. A test of this approach, modified to include minor treatment being accomplished at the school by mobile EPSDT teams, should be attempted in a project or operational environment in the immediate future.

c. Case Monitoring (Improved Rates of Treatment) Activities

(1) Introduction of a Distinct Case Monitoring System

(a) Antecedents

The link between screening and treatment of problems found in screening has been challenged, historically, as the program's weakest element.

In a survey of eight states conducted for SRS in 1973, it was found that only 46% of problems found in screening reached treatment.[1] In a survey conducted by a committee of the Congress in 1975, they reported 60.4% reached treatment.[2]

Following the 1973 survey and in reporting the results to the states, SRS emphasized that, "Follow-up on positive screens remains the most important program component to emphasize . . . It is further recommended that a formalized system of patient referral (with a referral log and feedback form) be used for case management."[3]

In this setting, the HSRI developed a model EPSDT data and managemnt system for demonstration projects. The Dallas project was designed, in part, to test systems and methods for improving rates of children receiving and completing treatment for problems found in screening.

At the time the Dallas project proposal was submitted by the State of Texas (1975), the Texas EPSDT program did not have a distinct case monitoring (follow-up) system, though multi-dutied case workers had been instructed to assist parents in obtaining treatment appointments. The Texas Department of Public

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[1] Information Memorandum, MSA-IM-74-11; MSA-SRS/DHEW, February 21, 1974.

[2] Dept. of Health, Education & Welfare's Administration of Health Programs: Shortchanging Children: Report of the Subcommittee on Oversight and Investigations of the Committee on Interstate and Foreign Commerce, House of Representatives, Ninety-fourth Congress, Second Session, September 1976.

[3] Information Memorandum, MSA-IM-74-11; MSA-SRS/DHEW, February 21, 1974.

Welfare, however, was fully aware of the need for a distinct case monitoring system, as is evidenced by its project proposal (the Dallas project) and its own developing, in embryo, case monitoring system.

In conjunction with the State, it was mutually agreed that the project's use of a case monitoring system would be a pre-test for the Texas system overall.

There was, however, one major philosophical difference between the project and the State case monitoring concepts. The project system, following the Health Services Research Institute model, was designed to follow a problem to final treatment resolution or administrative termination. The State system was intended to track the problem (or child) to a treatment provider (a first appointment--show for treatment).

This state of affairs then provided an excellent opportunity to determine the impact of introducing a distinct and structured case monitoring system upon the rate of children and problems receiving treatment.

(b) The Test

The major purpose of this test was to determine the impact of introducing a structured case monitoring system upon the rate of children and problems receiving treatment (first appointment).

An additional purpose was to determine the relative effectiveness of the State's limited process oriented case monitoring (to show for treatment) with the more extended project outcome oriented case monitoring (to treatment completion) on the rate of treatment completion.

1 Impact of Introducing a Structured Case Monitoring System on Rates of Problems Receiving Treatment (First Appointment)[1]

a Implementation

This test was based upon rates of "shows for treatment" in Sector D, the control sector, representing the ongoing program in two phases, i.e., (1) before the distinct case monitoring system was introduced, and (2) after it was implemented. The first phase covers the period from August through December 1975 and the second phase from May through December 1976. In both phases, random samples were selected of children who had referrable health conditions identified in the screening process. The sample (n) of problems for both groups represent the outcome of in excess of 2,000 EPSDT screens.

Group I (Pre-test) represented children who were screened and referred between August and December 1975.

The case monitoring system was initiated in February 1976.

Group II (Test) represented children who were screened and referred between May and December 1976.

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[1] Since the Texas Title XIX Dental Program is separately administered from the EPSDT program the problems indicated in this discussion are almost exclusively medical.

b Results

Group Description	Time Period Represented	Problem Sample Size (n)	Number and Rate of Shows for Treatment (1st Appt)*	
I (pre-test)	Aug.-Dec. 75	91	58	64%
II (test)	May-Dec. 76	109	93	85%

*The two proportions shown below are significantly different at p.<.0002

c Conclusion

This result represents a significant improvement (33%) in the show for treatment rate by introducing a distinct case monitoring system. These results are consistent with findings from a Nine State Survey of "shows for treatment" in the EPSDT program conducted for SRS/HCFA that States with established and distinct case monitoring systems could achieve show for treatment rates in the range of 80% - 90%.[1] Obviously, State programs that are still less advanced than the Texas program was in the pre-test phase have a potential for much higher rates of improvement.

2 Impact of Limited and Extended Case Monitoring on the Rate of Problem (Treatment) Completion

a Implementation

This test is based upon rates of problem completion between Group II, previously described as limited in follow-up to "show for treatment", and a third group, (III) which, as a project activity, is normally followed-up to "treatment completion".

The 76 problems randomly selected for Group III were drawn from a total of problem referral sheets (TDHR/DPW) from all three test sectors (A, B, and C) of the project for the period of February - December, 1976. These problems represent the results of over 800 EPSDT screens.

Follow-up assistance by case workers in Groups II and III included suggestions concerning provider availability, treatment appointment assistance, and transportation arrangements. Both the ongoing (Group II) and project (Group III) follow-up required up to three appointment efforts to achieve a successful first treatment appointment. Project follow-up (Group III) continued thereafter for at least six months or terminated earlier if treatment was completed. At the end of six months, the project was reminded monthly by the Health Services Research Institute of all cases (by name) that had not been closed, for continued follow-up. It was hypothesized that Group III would have a significantly higher rate of treatment completions than Group II.

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[1] Review of Shows for Treatment - EPSDT - A Nine State Survey, Health Services Research Institute, The University of Texas Health Science Center at San Antonio, Texas, March 31, 1977

b Results

The results of this test were:

Group Description	Time Period Represented	Problem Sample Size (n)	Number and Rate of Trtmt. Completions	
II (Limited follow-up)*	May-Dec. 76	109	79	85%
III (Extended follow-up)**	Feb.-Dec. 76	76	53	88%

*To show for treatment

**To treatment completion

c Discussion

Contrary to expectations, no significant difference was found in the treatment completion rates between these two groups. It may be that extended case monitoring (to treatment completion) is no more effective than limited case monitoring (to show for treatment) in achieving problem treatment completion.

The absence of significant differences between the groups may be due to the high proportion of problems in both groups that required only one treatment visit for completion, i.e.,

Number and Percent of Problems that Showed for
Treatment and Required One or More
Visits for Resolution

Group Designation	Treatment Period Represented	Problem Sample Size (n)	Number Showed for Treatment	No. of Trtmt. Visits Req. and Percent of Total Shows			
				1 Visit		2 or more visits	
II Limited Follow-up	May-Dec. '76	109	93	56	60%	37	(40%)
III Extended Follow-up	Feb.-Dec.'76	76	60	39	65%	21	(35%)

Approximately 62% of the problems required only one visit to complete treatment of the problem.

It is of interest to note that of the 64% of Group I that showed for treatment, and of which only an incidental type follow-up was available, essentially the same result was obtained, i.e., 60% of the problems that showed for treatment were resolved in one visit and 40% in subsequent visits.

These results suggest that once a client enters the treatment sequence (shows for treatment), the likelihood of treatment completion for medical problems is in the same order of magnitude with or without extended case monitoring.

d Conclusion

Results indicate that the introduction of a distinct case monitoring system[1] into an EPSDT program offers the potential of 80%-90% of problems found in screening reaching treatment.

Results also indicate that limited case monitoring to "show for treatment" offers as great a potential for treatment completion as does extended case monitoring through treatment completion.

3. General Project EPSDT Performance Results

Immediately following are schemata representing the tracking of all family contacts (1,055) made by the project from July 1, 1976 to June 30, 1977 from point of outreach contact to intermittent points of resolution or termination as appropriate through to ultimate treatment completion or other administrative termination.

Schema 1 is the tracking of combined original contacts and periodic recontacts.

Schema 2 is the tracking of the original contacts only.

Schema 3 is the tracking of the periodic rescreen contacts only.

A summation of selected primary program effectiveness indicators contained in these schemata follows. These indicators are considered to be quite reflective of the general status of the project's supporting program. Specific analysis of components being tested are addressed elsewhere in this report.

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[1] To include referral forms, treatment appointment assistance, transportation assistance, and provider/client feedback.

Table of Primary Program Effectiveness Indicators Derived From
An Analysis of 1,055 Family Contacts (July 1, 1976-June 30, 1977

	Overall	Original Screens	Periodic Rescreens
1. Of Families contacted - agreed to participate in the program	92%	91%	94%
2. Of children of families willing to participate - accepted screening appointments	99%	99%	99%
3. Of children appointed for screening - showed for screening*	70%	66%	73%
4. Of children screened - had medical problems	10%	10%	11%
5. Of problems identified in screening - showed for treatment	62%** (77%)	67%	53%
6. Of problems showing for treatment - confirmed at diagnosis and treatment	76%	85%	71%
7. Of problems confirmed - successfully resolved	59%	55%	72%
- administratively terminated	3%	4%	0
- still pending	38%	41%	28%

*To a total of three appointment attempts.

**Adjusted to include the current proportional distribution of the "as yet undetermined" would be 77% (see comment below).

Of the 1,055 family contacts for the 12 month period of July 1976 to June 1977, 71% were for original screenings and 29% for periodic rescreens.

The "show for screening" rate (line 3, preceding table) of 70% is a considerable improvement over the 57% reflected in the last report. It begins to reflect the true potential of the highly personalized case finding in-home approach combined with responsive transportation, accessible screening sites, and an effective, systemized management information system to identify eligibles and pinpoint incompleted actions. It must be emphasized, however, that the 70% rate is the result after three appointment attempts to achieve a successful show. This is beyond the effort of most operational programs. It is important to note that the rate would only have been 49% with a single appointment effort. An additional 21% of shows is achieved by the second and third appointment efforts.

The low rate of "problems found at screening" (line 4, preceding table) of 10% in the Dallas project area is most unique, both within the State and nationally. This is almost three times less than the overall State EPSDT problem referral rate of 28.4%.

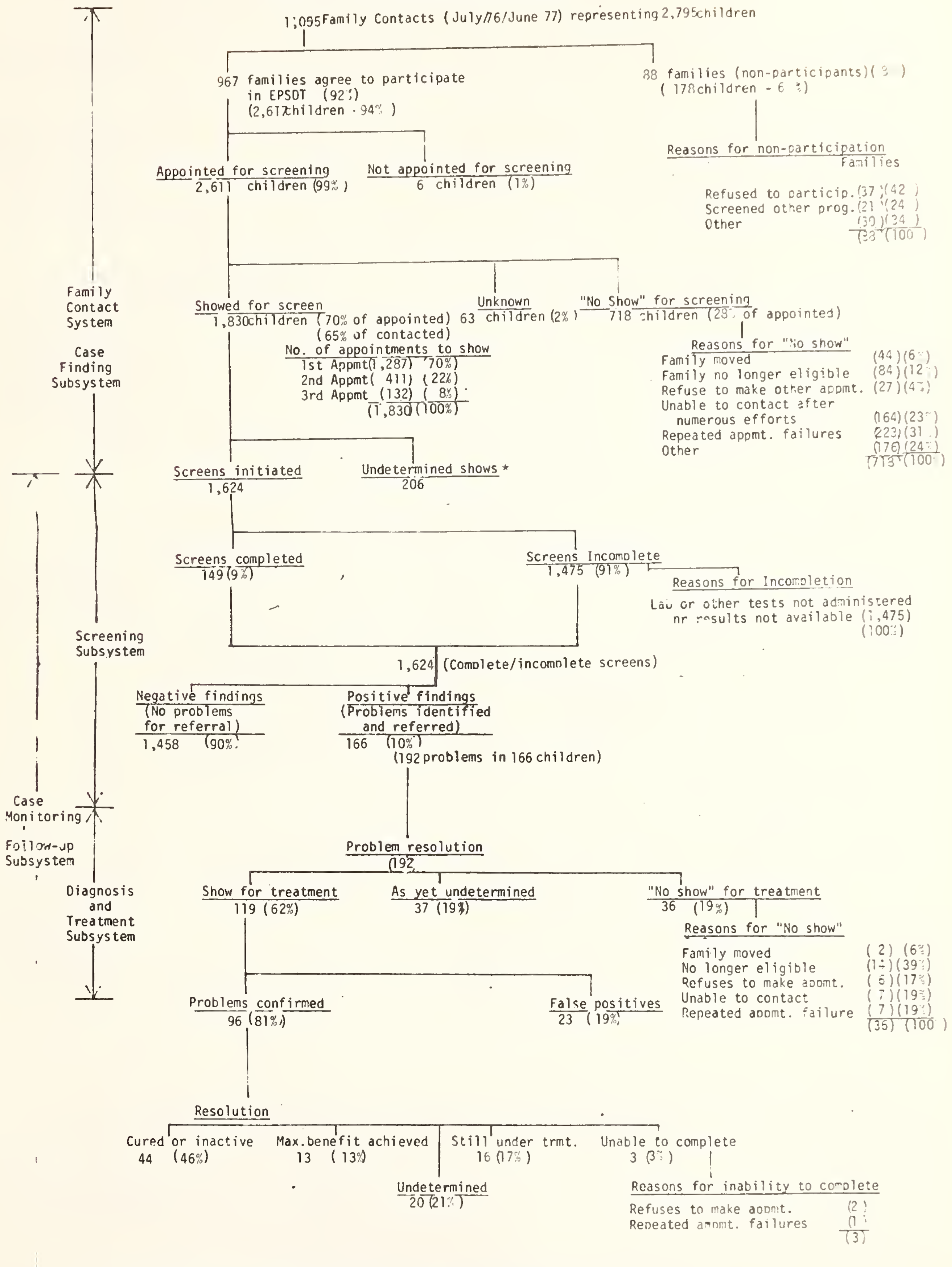
The "show for treatment" rate (line 5, preceding table) of an adjusted 77% is still somewhat low and in more time is expected to range between 80% - 90%. The distribution of the "as yet undetermined" (still in process) category should shift toward a more favorable "show for treatment" proportion when the current and projected case monitoring and screening techniques are fully reflected.

The distribution by cause of the adjusted 23% (or 44) of the "no show for treatment" category is as follows:

	No.	Percent Distribution of No-Shows by Cause
Family moved	3	6%
No longer eligible	18	39%*
Refused to make appointment	7	17%
Unable to contact	8	19%
Repeated appointment failures	8	19%
	44	100%

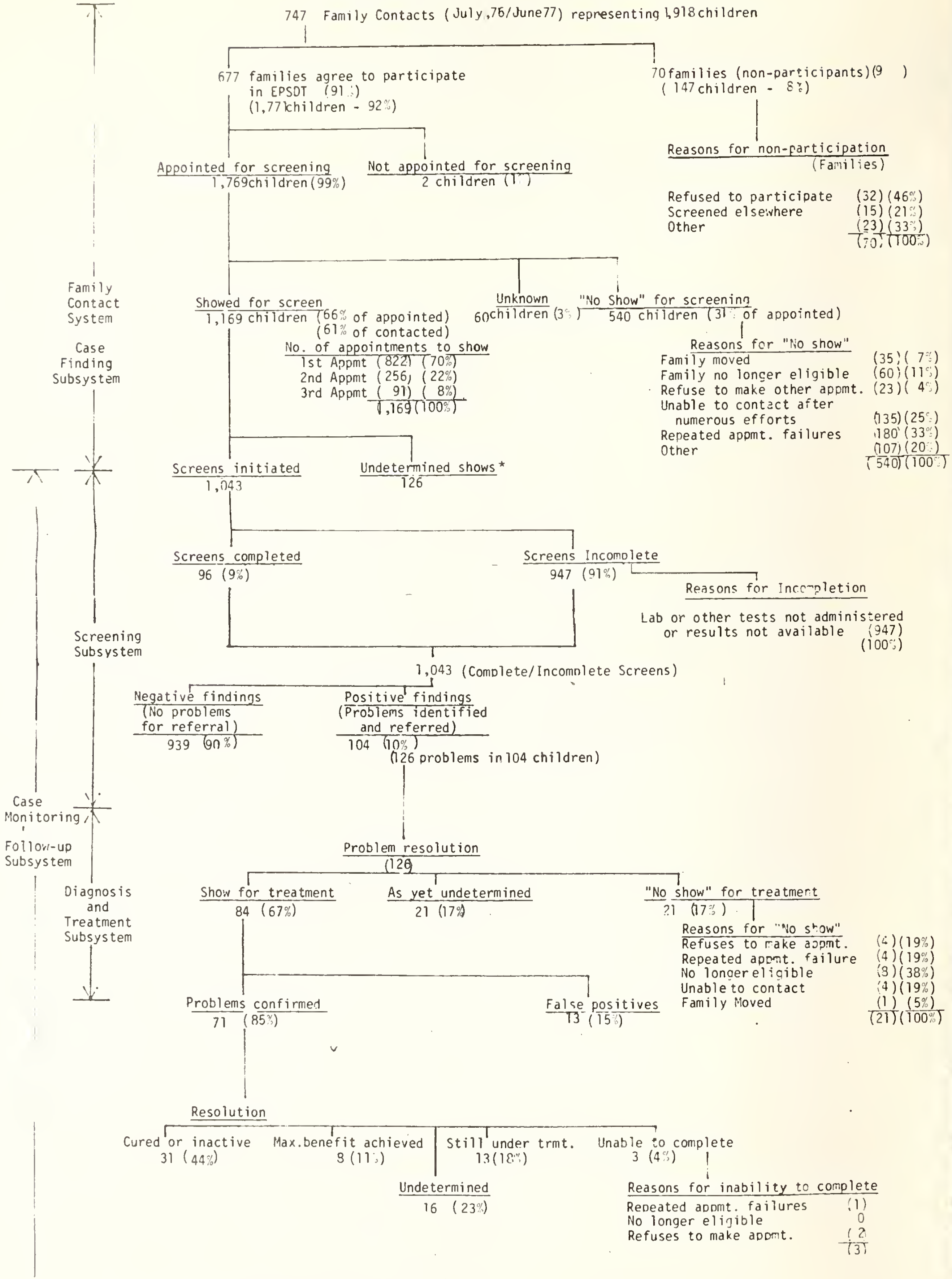
*This category of "no show for treatment" would be virtually eliminated by the proposed CHAP legislation which would modify the EPSDT program and extend periods of eligibility for treatment to six months for problems found in screening.

A "TRACK" THROUGH THE EPSDT PROGRAM OF 1,055 FAMILY CONTACTS
MADE IN JULY 76-June 77
DALLAS PROJECT
TOTAL - ORIGINAL AND PERIODIC RESCREENS


1,055 Family Contacts (July/76/June 77) representing 2,795 children
967 families agree to participate in EPSDT (92%) (2,617 children - 94%)
88 families (non-participants) (8) (178 children - 6 %)
Reasons for non-participation
Families
Refused to particip. (37) (42)
Screened other prog. (21) (24)
Other (30) (34)
(88) (100)
Appointed for screening 2,611 children (99%)
Not appointed for screening 6 children (1%)
Showed for screen 1,830 children (70% of appointed) (65% of contacted)
No. of appointments to show
1st Appmt (1,287) (70%)
2nd Appmt (411) (22%)
3rd Appmt (132) (8%)
(1,830) (100%)
Unknown 63 children (2%)
"No Show" for screening 718 children (28% of appointed)
Reasons for "No show"
Family moved (44) (6)
Family no longer eligible (84) (12)
Refuse to make other appmt. (27) (4)
Unable to contact after numerous efforts (164) (23)
Repeated appmt. failures (223) (31)
Other (176) (24)
(718) (100)
Screens initiated 1,624
Undetermined shows * 206
Screens completed 149 (9%)
Screens Incomplete 1,475 (91%)
Reasons for Incompletion
Lab or other tests not administered or results not available (1,475) (100%)
1,624 (Complete/incomplete screens)
Negative findings (No problems for referral) 1,458 (90%)
Positive findings (Problems identified and referred) 166 (10%)
(192 problems in 166 children)
Problem resolution (192)
Show for treatment 119 (62%)
As yet undetermined 37 (19%)
"No show" for treatment 36 (19%)
Reasons for "No show"
Family moved (2) (6%)
No longer eligible (14) (39%)
Refuses to make appmt. (6) (17%)
Unable to contact (7) (19%)
Repeated appmt. failure (7) (19%)
(35) (100)
Problems confirmed 96 (81%)
False positives 23 (19%)
Resolution
Cured or inactive 44 (46%)
Max. benefit achieved 13 (13%)
Still under trmt. 16 (17%)
Unable to complete 3 (3%)
Undetermined 20 (21%)
Reasons for inability to complete
Refuses to make appmt. (2)
Repeated appmt. failures (1)
(3)
Family Contact System
Case Finding Subsystem
Screening Subsystem
Case Monitoring Follow-up Subsystem
Diagnosis and Treatment Subsystem

*Family Contact Form indicates show for screen, but no screening forms are on file.

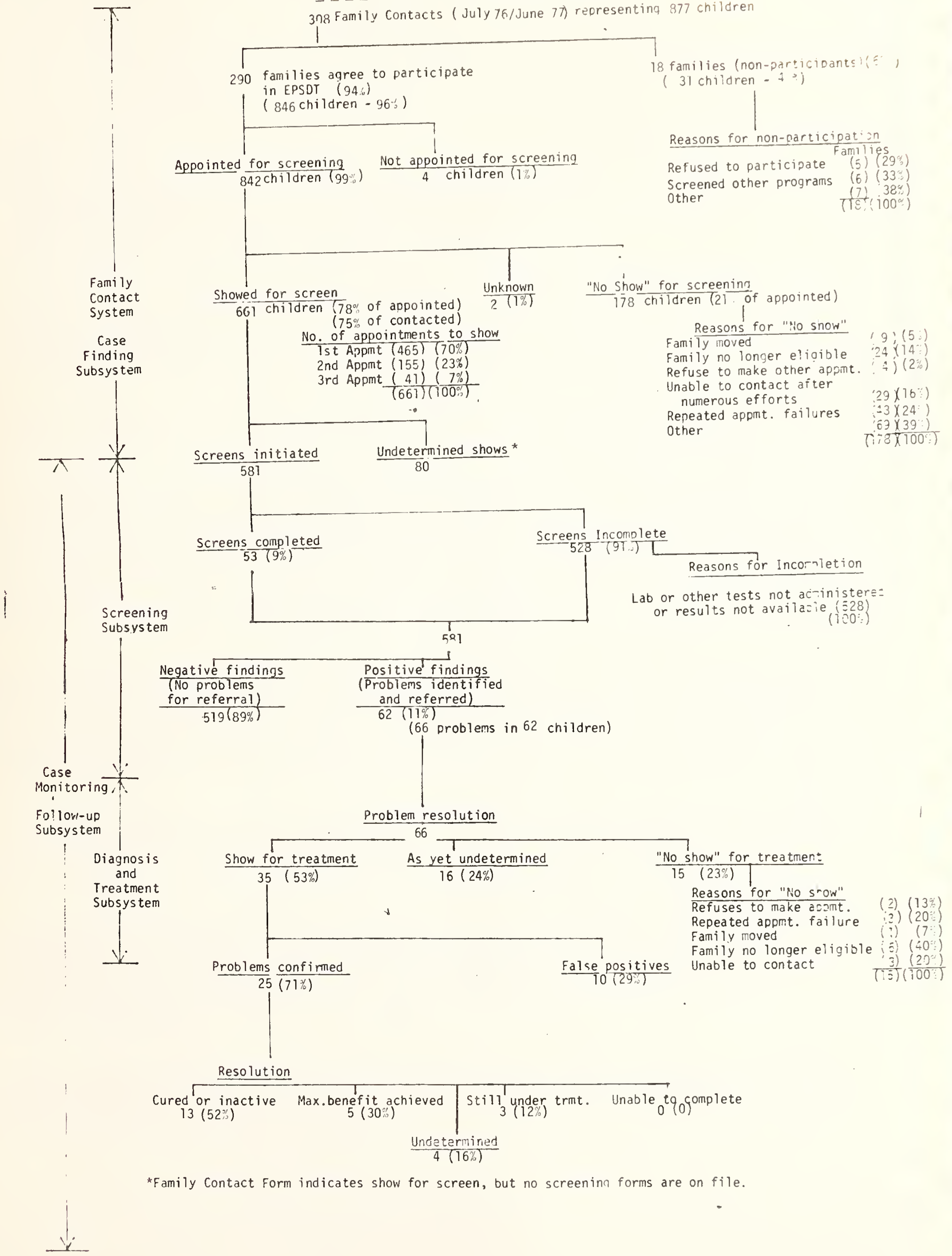
A "TRACK" THROUGH THE EPSDT PROGRAM OF 747 FAMILY CONTACTS
MADE IN JULY 76 - June 77
DALLAS PROJECT
ORIGINAL SCREENS ONLY


747 Family Contacts (July,76/June77) representing 1,918 children
677 families agree to participate in EPSDT (91%) (1,771 children - 92%)
70 families (non-participants) (9%) (147 children - 8%)
Reasons for non-participation (Families)
Refused to participate (32) (46%)
Screened elsewhere (15) (21%)
Other (23) (33%)
(70) (100%)
Appointed for screening 1,769 children (99%)
Not appointed for screening 2 children (1%)
Showed for screen 1,169 children (66% of appointed) (61% of contacted)
No. of appointments to show
1st Appmt (822) (70%)
2nd Appmt (256) (22%)
3rd Appmt (91) (8%)
(1,169) (100%)
Unknown 60 children (3%)
"No Show" for screening 540 children (31% of appointed)
Reasons for "No show"
Family moved (35) (7%)
Family no longer eligible (60) (11%)
Refuse to make other appmt. (23) (4%)
Unable to contact after numerous efforts (135) (25%)
Repeated appmt. failures (180) (33%)
Other (107) (20%)
(540) (100%)
Family Contact System
Case Finding Subsystem
Screens initiated 1,043
Undetermined shows* 126
Screens completed 96 (9%)
Screens Incomplete 947 (91%)
Reasons for Incompletion
Lab or other tests not administered or results not available (947) (100%)
Screening Subsystem
1,043 (Complete/Incomplete Screens)
Negative findings (No problems for referral) 939 (90%)
Positive findings (Problems identified and referred) 104 (10%) (126 problems in 104 children)
Case Monitoring/Follow-up Subsystem
Problem resolution (126)
Show for treatment 84 (67%)
As yet undetermined 21 (17%)
"No show" for treatment 21 (17%)
Reasons for "No show"
Refuses to make appmt. (4) (19%)
Repeated appmt. failure (4) (19%)
No longer eligible (8) (38%)
Unable to contact (4) (19%)
Family Moved (1) (5%)
(21) (100%)
Diagnosis and Treatment Subsystem
Problems confirmed 71 (85%)
False positives 13 (15%)
Resolution
Cured or inactive 31 (44%)
Max.benefit achieved 8 (11%)
Still under trmt. 13 (18%)
Unable to complete 3 (4%)
Undetermined 16 (23%)
Reasons for inability to complete
Repeated appmt. failures (1)
No longer eligible 0
Refuses to make appmt. (2)
(3)

*Family Contact Form indicates show for screen, but no screening forms are on file.

A "TRACK" THROUGH THE EPSDT PROGRAM OF 308 FAMILY CONTACTS
MADE IN JULY 76 - June 77
DALLAS PROJECT

PERIODIC RESCREENS ONLY


308 Family Contacts (July 76/June 77) representing 877 children
290 families agree to participate in EPSDT (94%) (846 children - 96%)
18 families (non-participants)(6%) (31 children - 4%)
Reasons for non-participation
Families
Refused to participate (5) (29%)
Screened other programs (6) (33%)
Other (7) (38%)
(18) (100%)
Appointed for screening
842 children (99%)
Not appointed for screening
4 children (1%)
Showed for screen
661 children (78% of appointed)
(75% of contacted)
No. of appointments to show
1st Appmt (465) (70%)
2nd Appmt (155) (23%)
3rd Appmt (41) (7%)
(661) (100%)
Unknown
2 (1%)
"No Show" for screening
178 children (21% of appointed)
Reasons for "No show"
Family moved (9) (5%)
Family no longer eligible (24) (14%)
Refuse to make other appmt. (4) (2%)
Unable to contact after numerous efforts (29) (16%)
Repeated appmt. failures (43) (24%)
Other (69) (39%)
(178) (100%)
Screens initiated
581
Undetermined shows *
80
Screens completed
53 (9%)
Screens Incomplete
528 (91%)
Reasons for Incompletion
Lab or other tests not administered or results not available (528) (100%)
581
Negative findings
(No problems for referral)
519 (89%)
Positive findings
(Problems identified and referred)
62 (11%)
(66 problems in 62 children)
Problem resolution
66
Show for treatment
35 (53%)
As yet undetermined
16 (24%)
"No show" for treatment
15 (23%)
Reasons for "No show"
Refuses to make appmt. (2) (13%)
Repeated appmt. failure (3) (20%)
Family moved (1) (7%)
Family no longer eligible (6) (40%)
Unable to contact (3) (20%)
(15) (100%)
Problems confirmed
25 (71%)
False positives
10 (29%)
Resolution
Cured or inactive
13 (52%)
Max.benefit achieved
5 (30%)
Still under trmt.
3 (12%)
Unable to complete
0 (0)
Undetermined
4 (16%)
Family Contact System
Case Finding Subsystem
Screening Subsystem
Case Monitoring, Follow-up Subsystem
Diagnosis and Treatment Subsystem

*Family Contact Form indicates show for screen, but no screening forms are on file.

CHAPTER I

INTRODUCTION

Background

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program was enacted into law as a section of Title XIX of the Social Security Act by the Social Security Amendments of 1967 (PL90-248).

Through this amendment Congress intended to require states to take aggressive steps to screen, diagnose and treat poor children with health problems. The Congress had been concerned about the variations from state to state in the rates of children treated for handicapping conditions and health problems that could ultimately lead to costly chronic illnesses and disability.

EPSDT, in the ideal sense, is intended to be a program for comprehensive preventive and health services for "poor" children (Medicaid eligible).

Notwithstanding the intent of the program, the unique federal/state sharing of its responsibility produced significant variations in the degree and manner in which the program has been implemented by the various states. The federal agency charged with program implementation, the Health Care Financing Administration (HCFA), DHEW, as recently as April 1977 acknowledged that the overall result to date of state programs was that only 30% of the 12 million children currently eligible were participating in the program.

Additionally, many critics of the program have been alleging since its inception that even those children who were participating were not adequately being provided treatment for health problems found in the screening process. In a survey of the EPSDT program in eight states, for example, in 1973 only 46.1% new problems found in screening were found to be treated through a Medicaid claims file check.

It was in this context of major concerns with lack of client participation in the program and failure to attain high rates of treatment for children with problems found in screening that the Dallas project was proposed.

Its specific objectives were to develop innovative, effective, and cost beneficial methods of case finding (outreach) to improve client participation in the EPSDT program and case monitoring (follow-up) to achieve increased rates of treatment for problems found in the screening process. The inbeing health care delivery system in Dallas was to be utilized for screening, diagnosis and treatment to the maximum extent possible.

The Dallas project, "EPSDT in an Urban Setting--Dallas, Texas" was approved and funded by the Social and Rehabilitation Service (later designated the Health Care Financing Administration), DHEW under Section 1115 of the Social Security

Act in July 1975. The grant to the Texas State Department of Public Welfare for the project represented an investment in both state and federal (SRS) interests in improving the EPSDT program.

Case Finding Activities

Most states had been found to rely heavily on client interest at the point of welfare application to offer advice concerning the program and then follow up with letters or flyers with welfare checks. These techniques had been found to be only minimally productive in inducing client participation in the program generally in the order of 10%-20%.

The initial major effort in case finding in the Dallas project was to test the highly personalized case finding technique of in-the-home/face-to-face contact between worker and client to offer information about the EPSDT programs to determine its impact on the participation rate.

The finding resulting from this test, as reported in the Phase II Evaluation Report, May 15, 1977, was that, although approximately 85% of clients contacted agreed to participate in the program, roughly 50% of them never kept a screening appointment although three appointment opportunities were attempted. This result prevailed notwithstanding a reasonably convenient clinic location (generally within an average of two to three miles from client homes), the provision of bus type transportation, a favorable clinic facility, and interested and concerned nurse-headed screening teams. This finding, if applicable to most other major urban areas, represented an unanticipated limitation to the program's potential.

A sequential test to this, in Phase III, is to test a materially reduced distance (and time) by a factor of seven between the client's home and screening site to determine the impact of increased accessibility and availability of health services (screening) on the program participation rate. This variable presupposes maintaining constant, to the maximum degree possible, all the circumstances surrounding the Phase I test, e.g., the same in-home/face-to-face client contact technique, same skill level of case workers, the same level of transportation availability and like circumstances of clinic surroundings and team-client interest.

This is the case finding test reported upon in this report.

An additional sequence approved for testing in this project in Phase IV, which is now in progress, is to determine the degree of success, the results, and the cost of "in-home" screening of those clients contacted in the two earlier phases but who failed to keep approximately six screening appointments.

This sequence of tests will afford policy makers a view of a sample of urban program-eligible clients across a spectrum of increasingly intensified case finding efforts to ascertain the probable levels of client program participation at the various levels of effort and cost.

Case Monitoring Activities

At the time of the project's conceptualization, most States had not made any special provisions for follow-up (case monitoring) in their EPSDT programs. This was due in part to the fact that most States split program responsibility for EPSDT between their Departments of Welfare and Departments of Health. Responsibilities for program elements generally "fell out" fairly clearly for outreach (case finding) to the Welfare Department and screening to the Health Department, with diagnosis and treatment most often by referral to providers in the private sector of health. Since screening was generally through contract between the two departments, follow-up was generally never assigned to the Health Department. Follow-up of referrals to treatment was not normally a traditional function of the Welfare Department, so was most often neglected or occasionally assigned as an additional duty to some case worker who already had many other family services responsibilities. This was the setting of circumstances that produced the finding of 46.1% of conditions found in screening reaching treatment, earlier referenced on page vi of this report.

The initial major efforts in this area in the Dallas project were to specifically identify case monitoring as a function of EPSDT and to institute a specific follow-up (case monitoring) system with full-time workers assigned to follow-up tasks (for problems and immunizations). Case monitors were, as case finders, to maximize the personal approach to clients through in-home/face-to-face contact to determine the impact on rates of treatment for problems found in screening.

The results of the introduction of a specific case monitoring system on show for treatment rates are included in this report.

Project Structure

As depicted on the cover, the project area is a sub-component of the City of Dallas made up of seven zip code areas, organized into four sectors, three of which are structured for experimental variations (Sectors A, B & C) and one as a control (Sector D). The control is intended to represent the activities of the "ongoing" prescribed EPSDT program. An arrangement that has evolved[1] since the project's original submission is the presence of both "ongoing" and "project" EPSDT activities in Sectors A, B & C. In effect, 40% of the eligible clients living in Sectors A, B & C are "project" (those whose Medicaid numbers end in 3, 5, 7 & 9) and 60% are "ongoing" (those whose Medicaid numbers end in 0, 1, 2, 4, 6 & 8). A detailed presentation of this distribution is as follows:

---

[1] Phase I and Phase II Evaluation Report for details.

DISTRIBUTION OF EPSDT PROGRAM ELIGIBLES BY SECTOR PROJECT AND "ON-GOING"[1]

Sector	Zip Code Area	EPSDT ELIGIBLES Total (100%)	Project (Approx. 40%)	On-Going (Approx. 60%)
A (A - J)	75203[2] 75208	3,583	1,378	2,205
B (K - Z)	75216 75224	3,328	1,280	2,048
C	75215	3,684	1,417	2,267
D (control)	75210 75223	3,086	(1,187)[3]	3,086[3a]
		13,681[4,6]	4,075[5]	9,606
		(17,785)	(5,297)	(12,488)

---

[1] Approximately December 31, 1976

[2] Sectors A/B share the same four zip codes with delineation by alphabetical designation (first letter of last name) as indicated

[3] Control

[3a] Includes the 1187 used for control purposes

[4,5] This is a more or less constant total; an annual client turnover rate ("on" and "off" welfare eligibility) of 30% would adjust the total to 17,785[4] and the project to 5,297[5].

[6] Generally 95% black; 3% Spanish surname; 2% Anglo.

Major Project Demonstration Activities

Following are schemata of the case finding and case monitoring activities in the project from Phase I through Phase III.

Throughout all these activities which are designed to maximize personal contact between client and worker, health education of clients is stressed. This was to be a non-evaluated objective. All workers in the project area with client contacts attended special health education classes.

The specific variables tested in this report period (Phase III) (January 1, 1977 - June 30, 1977) as to their impact on client participation in the program were:

Case Finding

. . . continue testing, full time case finding aides, using in-the-home/face-to-face contact during this period in connection with seven, instead of one, screening sites to ascertain the impact of increased accessibility and availability of health services on program participation rates.

. . . test the use of a specially designated "Young Adult Screening Clinic" (YAC) as a means of achieving greater participation of eligible teenagers in the EPSDT program.

. . . test the use of combined case finder/case monitor aides of varying skills doing in-the-home/face-to-face contact with clients to determine what program participation rates could be achieved, at what cost, and as compared to each other (skill levels) to "ongoing" (control) and to separate full time case finders.

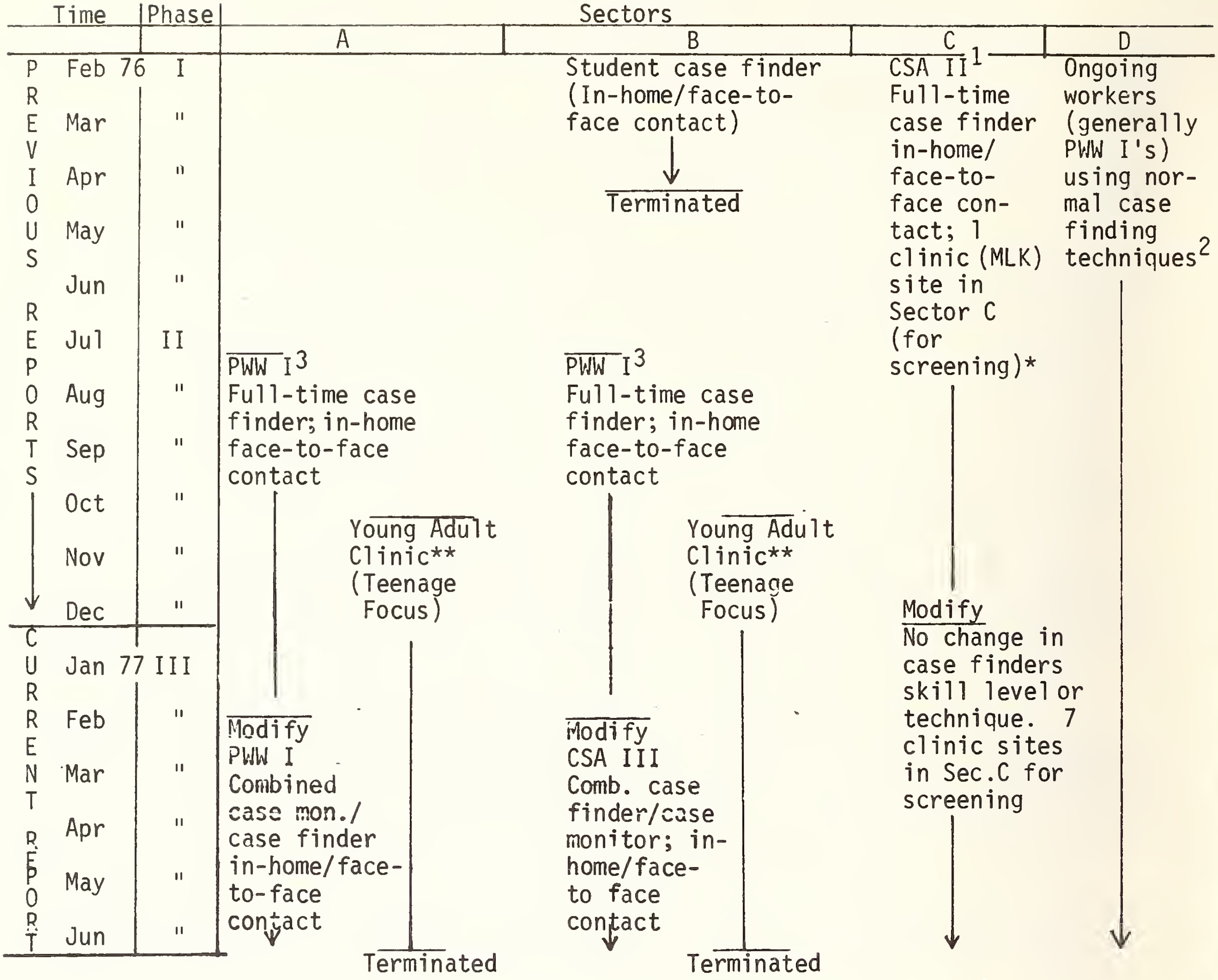
Case Monitoring

. . . test the impact of introducing a case monitoring system upon rates of shows for treatment.

. . . test the use of combined case finder/case monitor aides of varying skill levels doing in-the-home/face-to-face contact in a structured case monitoring system with clients to determine what "show for treatment" and "problem completion rates" could be achieved, at what cost, and as compared to each other (skill level) and to "ongoing" (control).

. . . continue testing the use of full time case monitoring aides using in-the-home/face-to-face contact in a structured case monitoring system to determine what "show for treatment" and "problem completion" rates could be achieved, at what cost, and as compared with other skill levels operating on a "part-time" basis (combined case finder/monitor).

Schematic
Case Finding Project Variables


Time
Phase
Sectors
A
B
C
D
PREVIOUS REPORTS
Feb 76 I
Mar "
Apr "
May "
Jun "
Jul II
Aug "
Sep "
Oct "
Nov "
Dec "
CURRENT REPORT
Jan 77 III
Feb "
Mar "
Apr "
May "
Jun "
Student case finder (In-home/face-to-face contact)
Terminated
CSA II[1] Full-time case finder in-home/face-to-face contact; 1 clinic (MLK) site in Sector C (for screening)*
Ongoing workers (generally PWW I's) using normal case finding techniques[2]
PWW I[3] Full-time case finder; in-home face-to-face contact
PWW I[3] Full-time case finder; in-home face-to-face contact
Young Adult Clinic** (Teenage Focus)
Young Adult Clinic** (Teenage Focus)
Modify No change in case finders skill level or technique. 7 clinic sites in Sec.C for screening
Modify PWW I Combined case mon./case finder in-home/face-to-face contact
Modify CSA III Comb. case finder/case monitor; in-home/face-to face contact
Terminated
Terminated

*Test impact of increased accessibility and availability of health services (screening) on participation rate of eligibles (show for screen; penetration rate)

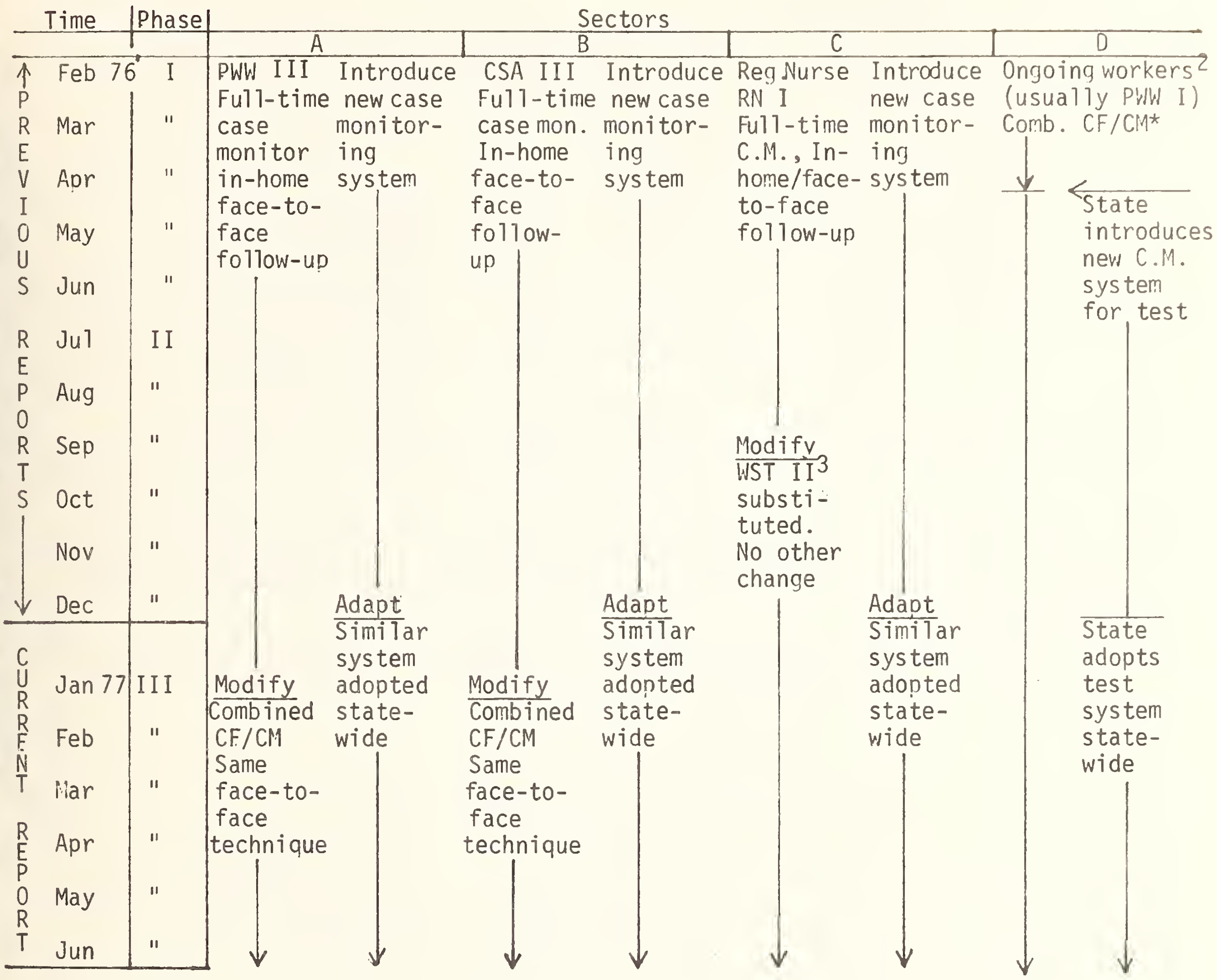
**Test impact of teenage oriented clinic on participation rate of teenage eligibles.

[1] Community Service Aides

[2] Generally PWW I's; worker time distribution: case finding - 70%, generally allocated as 30% letter contact effort; 20% sequential telephone contact effort; 20% sequential face-to-face contact either in-the-home or with transportation assistance.

[3] Public Welfare Worker I

Schematic
Case Monitoring Project Variables[1]


Time
Phase
Sectors
A
B
C
D
PREVIOUS REPORTS
Feb 76
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
CURRENT REPORT
Jan 77
Feb
Mar
Apr
May
Jun
I
II
III
"
PWW III Full-time case monitor in-home face-to-face follow-up
Introduce new case monitoring system
CSA III Full-time case mon. In-home face-to-face follow-up
Introduce new case monitoring system
Reg Nurse RN I Full-time C.M., In-home/face-to-face follow-up
Introduce new case monitoring system
Ongoing workers[2] (usually PWW I) Comb. CF/CM*
State introduces new C.M. system for test
Modify WST II[3] substituted. No other change
Adapt Similar system adopted state-wide
Modify Combined CF/CM Same face-to-face technique
Adapt Similar system adopted state-wide
Modify Combined CF/CM Same face-to-face technique
Adapt Similar system adopted state-wide
Adapt Similar system adopted state-wide
State adopts test system state-wide

*No specially designated case monitoring system in effect.

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[1] The case monitoring system established for Sectors A, B & C (test sectors) tracks problems found in screening to treatment and treatment completion. The control sector system (D) introduced in May only seeks to track problems to treatment--this latter tracking satisfies legal and federal programmatic requirements.

[2] Ongoing workers, generally PWW's, with combined case finding/case monitoring responsibilities. Contacts with clients for follow-up are normally through letters or telephone contact and only personal contact (in-home) if the first two means of contact fail. Personal contact is minimal as compared to the test sector workers where personal contact is maximal.

[3] Welfare Service Technician.

Schedule of Evaluation Reports

In terms of the current report requirements stipulated by HCFA, four evaluation reports are projected for the project over the three years of its approved duration, as follows:

Report No.	Period Covered	Due Date
1	Feb. 1, 1976 - June 30, 1976	October 15, 1976 (Completed)
2	Feb. 1, 1976 - Dec. 31, 1976	April 15, 1977 (Completed)
3	Feb. 1, 1976 - June 30, 1977	November 15, 1977 (This report)
4 (Final)	Feb. 1, 1976 - June 30, 1978	September 30, 1978

As a format in general, reports No. 1, 2, and 4 are to be complete in themselves. The project historical perspectives chapter and the data systems chapter, including the data collection forms, etc., are to be included in each of these reports.

Report No. 3 (this report) does not include these chapters on historical perspectives and data systems.

Chapter II

CASE FINDING

Test Objectives

The major test in case finding in this report period was to determine the impact of increased accessibility of screening sites to clients on their EPSDT program participation. This was to be a phased test in which the increased accessibility was to be superimposed upon a functioning case finding model consisting of full time community service aides (skill level) contacting clients through in-the-home/face-to-face contact (technique).

Secondary test efforts were concerned with (1) specially designated "Young Adult Clinics" as a means of achieving greater participation of young adults (13-21) in the EPSDT program, and (2) ascertaining the relative effectiveness of full time case finders as compared with combined case finders/case monitors.

Schema for Project Case Finding Activities (January 1977 - June 1977)

The overall schema for case finding in the project to date is contained in the schema in Chapter I, page 6. The schema below portrays the case finding activities for the project for this report period only.

SCHEMA

Case Finding Project Activities (Jan 77 - Jun 77)

Time	Project Phase	SECTOR A	SECTOR B	SECTOR C	SECTOR D
Jan.77	III	Full Time Case Finder (Modify)	Full Time Case Finder (Modify)		Ongoing Activity Combined CF/CM Ltr/Tele/In-home (PWW I)
F	"			Full Time Case Finder (CSA II) In-home/Face-to-face Contact (7 Screening sites)	
M	"	YAC (Teenage Focus)	YAC (Teenage Focus)		
A	"	Comb. CF/ CM In-home/ Face-to-face Cont.(PWW I)	Comb. CF/ CM In-home/ Face-to-face (CSA III)		
M	"				
J	"				

Program Eligibles (Target Population)

The target population (program eligibles) toward whom these case finding activities were directed was approximately as follows, on June 30, 1977:

Project Area Eligible Population
(By Family, Children and Sector)

Sector	No. of Family Units	No. of Children	Approximate Cumulative Annual No. of Program Eligible Children*
A	486	1,379	1,793
B	500	1,319	1,715
C	556	1,412	1,836
Subtotal	(1,542)	(4,110)	(5,344)
D (Control)	409	1,088	1,414
Total	1,951	5,198	6,758

Evaluation Effectiveness Measurement Rates

The rates to be utilized in the measurement of the effectiveness of these case finding activities are as follows:

Rate	Formula		
1. Rate of family contacts by type aide, by time (per week) Original contact Periodic rescreen contact	$\frac{\text{No. of family contacts by category of aide}}{\text{Weeks or months}}$	=	Rate of contact per week or month by type aide
2. Rate of appointments made (of total eligible children in eligible families contacted)	$\frac{\text{No. first appointments made}}{\text{No. eligible children in families contacted}}$	=	Rate of first appmts. made at end of 90-days, by type aide
3. Rate of appointments kept (of appointments made) (shows for screen rate)	$\frac{\text{No. appointments kept}}{\text{No. appointments made}}$	=	Rate of appmts. kept at end of 90 days, by type aide
4. Rate of program participation (Population penetration rate) Separate by age categories 0- 5; 6-12; 13-18; 19-20	$\frac{\text{No. of shows for screening (of denominator)}}{\text{No. eligibles (in sectors) on last day of report period}}$	=	Rate of program participation (by sector) by technique being tested (by age group)

---

*Number of children, adjusted to reflect an annual 30% turnover rate on the DPW eligibility rolls.

Evaluation of Variables

Following is the evaluation of the three case finding variables tested in this report period, i. e.,

(1) Increased accessibility and availability of EPSDT health activities (multiple (neighborhood) screening sites).

(2) Use of specialized screening clinics for young adult eligibles.

(3) Use of combined case finders/case monitors of various skill levels.

1. Use of Multiple Screening Sites (Neighborhood Clinics)

a. Antecedents

In the first phase of this project, the highly personalized in-the-home/face-to-face client contact technique utilized in Sector C only produced a 51% kept appointment rate after three attempts to achieve a successful appointment. The show for screen rates (kept appointment rate) by appointment sequence was as follows:

Sector C

Proportion of Children Accepting Appointments
Who Kept Appointments

Appointment Sequence	Number Kept	Percent of Those Willing And Appointed (1,365)
First	457	34%
Second	197	14%
Third	42	3%
Total	696	51%

This result was disappointing since the technique of using outreach personnel indigenous to the target area in a personal, face-to-face/in-the-home contact with the client was considered to be potentially one of the most effective by many of the program advocates. Additionally, the full time equivalent (FTE) case finder to eligible population ratio of one to 545 appeared to be more than adequate to achieve good results. This ratio was almost twice the worker/population density of the control sector (D) representing the ongoing program in Dallas which was producing a population participation rate of approximately 40% - 45%.

During this phase (February 76 - December 76) there was only one screening clinic, the Martin Luther King Clinic, serving Sector C.

In light of the highly favorable case finding/outreach services provided, it was proposed in a second phase of activity to attempt to determine the impact on EPSDT participation of improved accessibility and availability of health services (screening sites) to the client. In this instance, every attempt would need to be made to hold constant through Phase II those program elements from Phase I that could otherwise influence the results--such as outreach technique and worker qualifications, transportation, screening components, etc.

b. Objective--Multiple Screening Sites

The purpose of increasing the number of screening sites was to determine the impact on EPSDT program participation of increased availability and accessibility of health services (screening sites).

c. Evaluation

Evaluation of the effectiveness of this method to increase program participation is to be predicated upon standing rates for measuring case finding activities in the project, e.g., family contact response rates, kept appointment rates, and eligible population program participation rates.

d. Program of Implementation

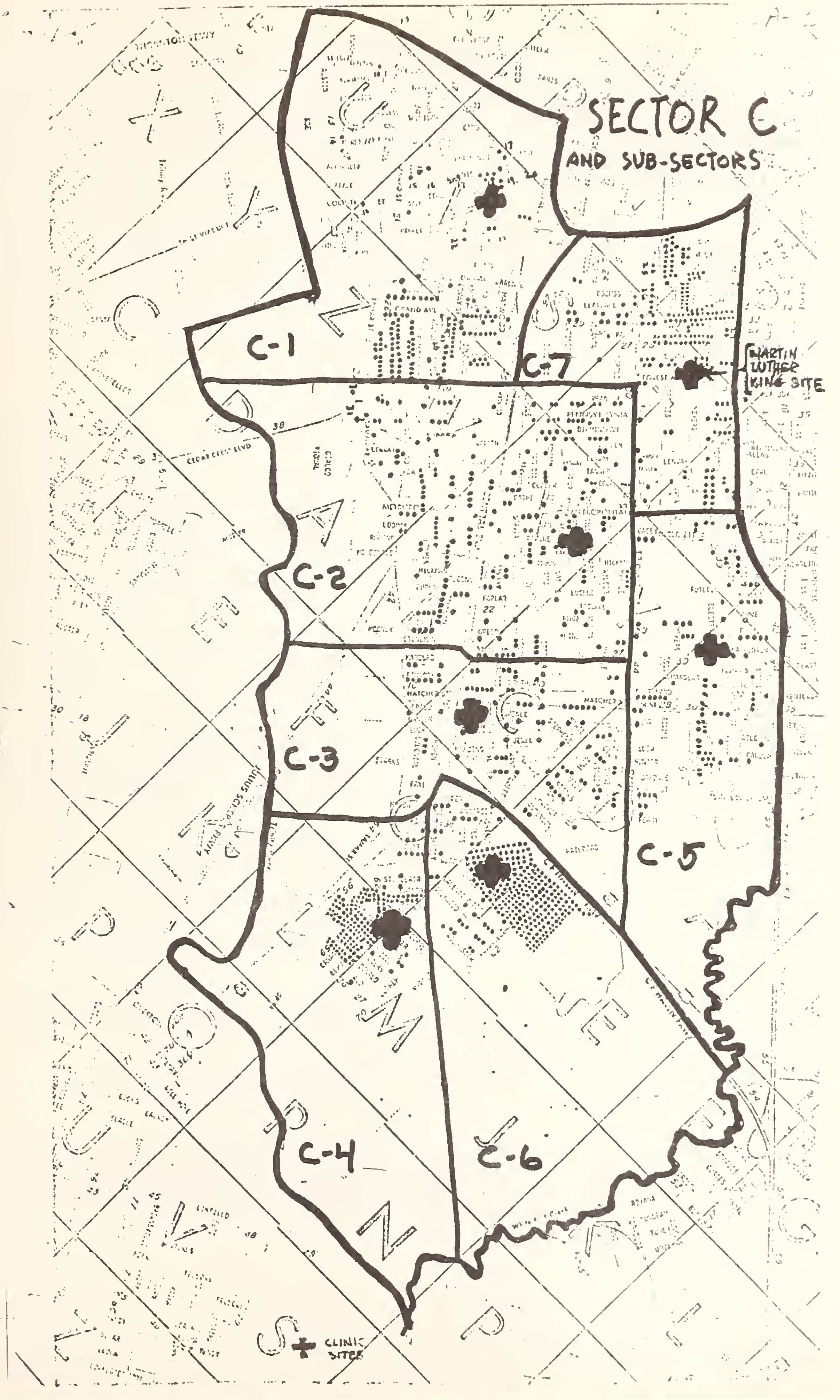
(1) Location, Number and Accessibility of Screening Sites

The number of screening sites in Sector C was increased from one to seven, and the sector accordingly sub-divided into seven related sub-sectors. The Martin Luther King Clinic remained as one of the seven sites. The average distance from home to screening site in Sector C was reduced from 2.5 miles (or approximately 50 city blocks) to 0.4 miles (or approximately eight to ten city blocks). A map depicting the sector subsectors and associated screening sites follows on the next page.

In each of the six subsectors, other than C-7 to be served by the Martin Luther King site, arrangements were made with community activities for the use of building space without cost to conduct the screening. These agencies and the screening locations, plotted on the accompanying map, are as follows:

Subsector	Agency and Facility
C-1	Ervay Baptist Church
C-2	South Dallas YMCA/St. Phillips Episcopal Church/ Warren Avenue Christian Church
C-3	New Hope Baptist Church
C-4	Turner Court Housing Project Auditorium
C-5	Hope Community Church
C-6	Rhodes Terrace Housing Project Day Care Center

SECTOR C
AND SUB-SECTORS



(2) Schedule of Multiple Screening Clinics (Neighborhood Clinics)

Generally, the project screening team rotated through the six sites (C-1 through C-6) on a six week cycle, holding clinics at these sites one day per week. The regular City of Dallas EPSDT screening team provided screening services for Sector C-7 at the Martin Luther King Clinic two to three times per month.

The one day per week clinic was adequate to handle the number of cases available in each subsector. This was a result of the previous intensive case finding efforts that had been conducted in Sector C. As indicated earlier, approximately 50% of the eligible constant population of children (roughly 1,400) in Sector C had been brought into the program by the case finding efforts conducted from February 1976 to December 1976.

(3) Organizational Arrangements

As indicated in this and previous reports, the EPSDT screening in Dallas is normally accomplished by the City of Dallas Health Department screening team. The team serviced, and continues to service, the Martin Luther King site. In order to implement this test, however, it was necessary to establish an additional screening team. This supplemental team was established through the grant and funded as a project entity. The team was organized to function closely parallel to the City of Dallas team in an effort to hold differences in "screening delivery" to a minimum that might have an impact on client participation rates. The City of Dallas EPSDT Screening Director, as well as the Texas Department of Health Resources (TDHR) provided technical assistance and some training of the nursing staff. The nursing staff, as in the City of Dallas Screening Team, were the professional screeners, assisted by medical technicians and administrative personnel. The Dallas Health Department team was supervised by a physician. The project employed a physician as a consultant to exercise professional overview of the screening team's activities and offer professional consultation on specific cases when requested. This physician also reviews all EPSDT screening results (TDHR-DPW Forms 400) accomplished by the project screening team and makes all referrals for treatment.

Literally all EPSDT screening within the State is accomplished through contract with the Texas Department of Health by the Texas Department of Human Resources (Welfare Department). Outreach (case finding) and case monitoring are functions of the Department of Human Resources and its associated agencies at county/city levels.

In this singular instance in the state, under the arrangement established to implement this test, outreach, screening and case monitoring are components of the same administrative entity--the project.

(4) Outreach and Follow-up (Techniques and Worker Skill Levels)

As earlier stated, the techniques and skill levels of persons involved in these functions were continued without change from Phase I in this sector in order to minimize their influence on whatever changes of results in client participation in EPSDT might emerge from the increased accessibility of health services (screening sites).

This technique involved in-the-home/face-to-face contact to solicit program participation (case finding) and to assure high rates of treatment for problems found in screening. Two Community Service Aides II perform full time outreach for the neighborhood clinics and one Welfare Service Technician II performs full-time follow-up.

A complete description of the qualifications of these workers and procedures utilized are either contained elsewhere in this report or in Evaluation Report Phase II, February-December 1976, dated May 15, 1977. A summary flow chart of the outreach procedures for the "neighborhood clinics" follows on the next page.

(5) Screening

(a) Clinic staffing

The project screening team for the neighborhood clinics normally consists of two registered nurses, two to four volunteers, and a registration clerk.

The team is drawn from a pool of two registered nurses (both of whom are certified as Family Nurse Practitioners, and 11 volunteers trained in the basic screening procedures and provided through arrangements with the Dallas chapter of the National Council of Jewish Woman Volunteers.

All personnel, except the volunteers, are paid employees of the project.

(b) Management and Process

The project Health Coordinator, who also functions as one of the two screening nurses, worked with the Texas Department of Health and the City of Dallas Health Department to coordinate screening procedures and standards. The conduct of the screening was subject to review at all times by both these agencies, as well as by the project medical consultant.

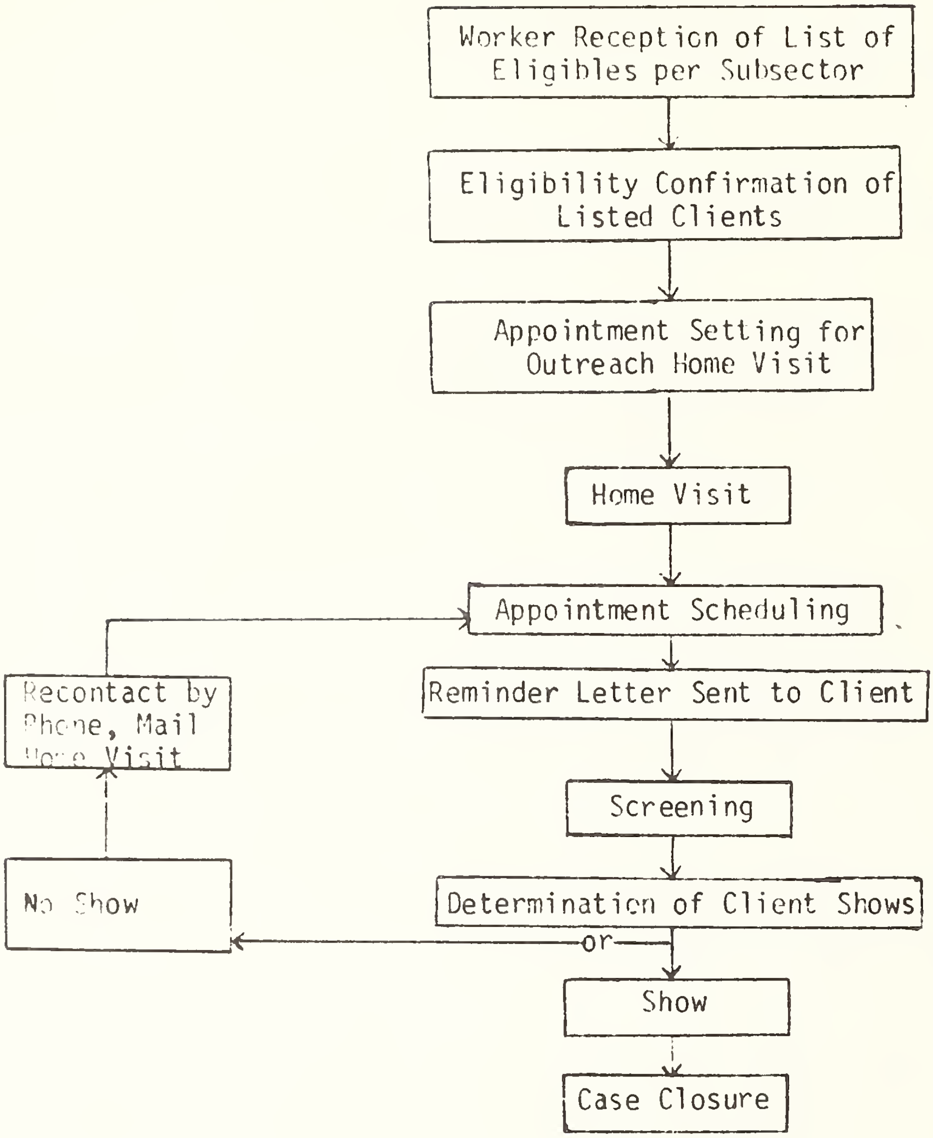
The Health Coordinator and the supervisory nurse performed the following functions for the team in addition to screening, per se;

1. Locate, inspect and appropriately arrange for clinic sites.
2. Determine clinic dates.
3. Maintain equipment and supplies.
4. Supervise activities at the clinic site.
5. Assist in training volunteers in medical procedures.
6. Administer the relationship with the medical consultant to oversee proper meeting of the contract requirements.
7. Coordinate with volunteer chairpersons for the required amount of volunteer assistance per clinic.

The equipment and supplies are transported to the respective sites (C-1 through C-6) for each clinic by the project van and set up by the nurse, driver, and clerk under the supervision of the team nurse.

FLOW CHART

Outreach Procedures for the Neighborhood Clinics


Worker Reception of List of Eligibles per Subsector
Eligibility Confirmation of Listed Clients
Appointment Setting for Outreach Home Visit
Home Visit
Appointment Scheduling
Reminder Letter Sent to Client
Screening
Determination of Client Shows
or
Show
Case Closure
No Show
Recontact by Phone, Mail Home Visit

(c) Tests and Measurements Administered

The screening package offered by the project screening team serving the neighborhood clinics is essentially the same as for the Dallas City Health Department and the State of Texas in general, except as indicated below, all of which are compatible with federal guidelines for EPSDT screening.

Differences in the Screening Process

Screening Assessment	Dallas City Health Dept. EPSDT Screening	Project EPSDT Screening
Hearing	Pure Tone Audiometer	Electroacoustic Impedance Bridge
Developmental (0-6 years of age)	Gross Subjective Assessment - Denver Developmental administered if other indicators from child history or observation suggest the existence of a possible problem.	Denver Developmental Screening Test
(7-12 years of age)	As above	As the Dallas City Health Department

In both above instances, the literature supports their alternative employment. There may be a challenge from some sources concerning a bias in the Denver Developmental Screening Test for a predominantly Black group of children, but it is still a test listed for this purpose by the American Academy of Pediatrics in their Guide to Screening.[1]

The Impedance Bridge is purported to be more accurate and more cost beneficial in the long term than the Pure Tone Audiometer.[2]

(6) Factors Influencing the Results other than the Major Variables Being Tested

Though in a theoretical sense all participants in this demonstration project (state, city, project staff and evaluators) may agree upon the need to hold constant one set of variables in order to conduct a test of another single variable to determine its impact upon a group or a process, this is rarely ever fully realized in a project conducted in an operational environment. The Dallas project fits this mold. The evaluation of this test has surfaced some shifting in desired constants such as transportation, management, and structure, as well as relationships between the mother and the screening process that doubtlessly will have some limited impact of their own on the results obtained in this test.

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[1] A Guide to Screening-EPSDT-Medicaid, The American Academy of Pediatrics, William K. Frankenberg, M.D., A. Frederick North, M.D., June 1974.

[2] An Abbreviated Impedance Bridge Technique for School Screening, J.C. Cooper, Ph.D., George Gates, M.D., Jeffrey Owen, Harold D. Dickson, Ph.D., Journal of Speech and Hearing Disorders, May 1975 (Vol. 40, No.2).

These variables and the differences that have occurred to affect a time sequence ("before and after") comparison are as follows:

	Desired Constant	Difference
Activity	Description of Activity Before the Test Period	Description of Activity During the Test Period
Transportation	Transportation of clients from home to screening site and return was accomplished by a van or bus operated by a private transportation company under contract to the Welfare Agency. Clients were generally required to be prepared for pick-up at home some two hours in advance of scheduled pick-up time. This offered the transportation contractee a two-hour leeway in pick-up. Client might have to wait up to two hours at completion of screening to be transported home. In the months of January-April in this report period, the ongoing DPW EPSDT program support units had a case worker ride the van/bus to assist the driver in locating client homes and assisting the mothers with children.	It was not possible to arrange for the transportation contractee to adjust his schedule to include the seven neighborhood clinics and associated catchment subsectors. The project operates its own transportation van. Operating in a much smaller compartment of space (subsector), the project van is able to be more precise in its pick-up and return home schedules. The van is under control of the nurse screening team supervisor who may alter the van operation at a moment's notice to be more responsive to the client. Total time committed by a mother to the total activity of participating in an EPSDT screen is significantly reduced (an estimated average of 25%) as a result of the more responsive transportation. Informal query of clients indicates this is a major consideration in their decision to participate in EPSDT.

Activity	Description of Activity Before the Test Period	Description of Activity During the Test Period
Management and Structure	The outreach (case finding) and screening activities and associated personnel are each respectively under different departments and supervisors, i.e., the Dept. of Public Welfare (Human Resources) and the Dept. of Health. Basic team size does not vary according to numbers of children scheduled.	Outreach, screening and case monitoring activities are under the same overall management/supervision. There may be a modicum of increased effectiveness in the provision of EPSDT services through this single management organization that may have a more favorable client response. By utilizing volunteers, more team members can be available when larger clinics are anticipated. This allows for consistent, personalized recepient attention and opportunity to do health teaching.
Relationship between the Mother and Screening Process	The mother is often absent during the physical assessment. The nurse may or may not discuss the referral problem with the mother. The screening nurses originate referral forms for children requiring treatment of problems found in screening. A designated DPW worker at the screening site discusses the referral with the mother and begins the treatment appointment scheduling process.	The mothers are encouraged to accompany the child through the physical examination component of the screen. The nurses initiate the referral form for children requiring treatment of problems found in screening. The nurse discusses the problem and reasons for referral with the mother personally and assists the mother in the scheduling of the first treatment appointment.

Though a mother might not be made aware of these differences through the case finding contacts so as to affect her decision to participate in the program or keep scheduled appointments, there is assumed to be sufficient word of mouth communication in the neighborhoods as to have an impact on her actions.

(7) Results

(a) Rate of Contact of Eligible Families in Sector C*

Number of Eligible Families (as of June 30, 1977)	Number and Percent of Eligible Families Contacted July 1, 1976 to June 30, 1977
556	366 - (66%)

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*Data derived from the State DPW Monthly Eligibility Tapes and HSRI Family Contact File.

Discussion:

This rate in this instance is not, in itself, a measure of the effectiveness of the variable being tested (multiple sites). It is intended to be indicative of the continued effort in this sector to contact all the eligible families.

The family contact rate at the end of the last report period (December 31, 1976) was 80%. The current rate (June 30, 1977) is 66%. This change to a lower rate is not really reflective of the continued high degree of intensive case finding that prevails. It is more a result of an influx of large numbers of clients into the number of eligible families (the denominator) in the latter part of the referral period who had been contacted in February-June 1976 and were now, one year later, still certified Medicaid eligible and due (re-eligible) for recontact. This includes recontact of those who had agreed to participate in the program and then failed to keep their screening appointments and were therefore ineligible for EPSDT recontact for one year[1] (still considered an initial contact) as well as those who had been contacted and kept a screening appointment and were now due for the annual periodic rescreen. The 556 eligible families, of course, also include newly certified welfare clients.

(b) Rate of Family Contacts by Time Period and Full Time Equivalent (FTE) of Case Finder Effort - Sector C*

Time Period	No. of Contacts	Avg. No. of Case Finding FTEs Available	Family Contacts Per FTE by Time Component			
			Total Contacts in Period	Average Contacts		
				Per Month	Per Week	Per Day
Feb.76-Dec.76 (11 months)	619	2.61	237.2	21.5	4.95	.99
Ja.77-June.77 (6 months)	214	1.89	113.2	18.9	4.38	.87

*Data derived from Family Contact File.

Discussion:

Again, as with the preceding table, this rate in itself is not intended to be a measure of the effectiveness of the variable being tested (multiple sites) but is intended to reflect the continued intensity of the case finding effort in Sector C.

The contacts per FTE of case finding effort per comparable time component remain relatively constant. Notwithstanding, there were changes in the case finding activity that could have reflected changes in effort, but two differences in operational circumstances between the two time periods under comparison appear to counterbalance each other.

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[1] In accordance with the annual EPSDT periodicity prevailing in the Dallas region.

pick-up time. At least one hour was projected for the screening itself and a one to two hour wait for return transportation was not uncommon.

The importance of the mother's perception of the length of time committed to the EPSDT process and related convenience of the seven neighborhood sites may be aptly illustrated by the means they chose to get to the screening site in the two respective phases, i.e.,

Mode of Transportation to Screening Clinics
Utilized in Two Periods of Time - Sector C

	Jul.-Dec. 76 1 Screening Site		Jan.-Jun. 77 7 Screening Sites	
	No. Cases	% of Total	No. Cases	% of Total
Drove self	43	13.2%	44	9.4%
Brought by Welfare staff	27	8.3%	5	1.1%
Rode with friend/relative	24	16.6%	52	11.1%
Walked	60	18.4%	156	33.2%
Rode bus/taxi (Pub.trans)	70	21.5%	38	8.1%
Rode welfare vehicle	57	17.5%	158	33.6%
Other	15	4.6%	17	3.6%
Total	326	100%	470	100%

The rate of those walking increased by 80% (from 18.4% to 33.2%) and those using project provided transportation ("Rode welfare vehicle") by 92% (from 17.5% to 33.6%). In the first phase (July-December 76) the category "Rode welfare vehicle" applied to the normal DPW contracted transportation. In the second phase, this category applied to the project provided van. In the latter instance, the transportation was usually far more responsive in time to the client's needs. In this phase, the project van was operating in a significantly smaller area than the DPW contracted transportation and servicing a reduced number of clients on a daily basis. The project did not stipulate that the client be ready by more than 15 minutes prior to scheduled pick-up time.

In Phase II (neighborhood clinics) the mother may have perceived her total investment in time in the EPSDT process in the range of two to three hours, as compared with three to five hours in Phase I.

Affecting, to an unknown degree, the mode of transportation used is the shift that occurred between the two periods in the category"Rode bus/taxi (public transportation)". It is estimated that the change in this category from 21.5% to 8.1% was largely absorbed into the category of "Rode welfare vehicle". This decline in use of public transportation related in some degree to the location of public transportation (bus) routes and the location of the neighborhood clinics that may not have been as convenient to those routes as was the Martin Luther King Clinic.

In the overall, however, the consensus weighs heavily in according the increased availability and accessibility of health services, the seven neighborhood sites, and the concomitant reduction in total time necessary for a mother and children to complete the screen and related activities, as the major factors in the highly improved kept appointment rates.

(e) Rate of Program Participation (Penetration Rate), Neighborhood Clinics, Sector C* in Two Periods of Time

Time Period	No. of Eligibles (Children) In Sector C as of Dec.31,76	June.30,77	Who Showed for Screen as of Dec.31,76	June.30,77	Annualized Projected Shows for Screen No.	Rate**	Annualized Average Projected Case Finding FTEs Available
Feb.76-Dec.76 (11 months)	1,417	///////	662	//////	722	51%***	2.60
Jan.77-Jun.77 (6 months)	/////	1,412	//////	420	840	60%***	1.89

*Data derived from Texas DPW Monthly Eligibility Tapes and HSRI Screening Files

**Penetration Rate

***The rates are different at the $p. < .0001$ level of significance.

Discussion

The attainment of the annualized potential 60% program participation rate[1] is a significant accomplishment. It represents a uniquely high level of participation in an urban center and associates with a specific model of case finding/screening accessibility. The true level of participation (penetration) in this mode may be somewhat higher when tested over a longer period of time than six months since the short range rates of appointments made of those contacted has reached 98% and the rate of appointments kept has reached 74%.

At this point, however, it is not possible to state that these demonstrated increases in program participation are due solely to the increased accessibility of health services through the means of the additional neighborhood clinics. Though the main components of the case finding effort, such as the in-home/face-to-face contact technique and the skill level of the case finder (CSA II), were held constant during the two periods under comparison, other variables that needed to be held constant shifted sufficiently in emphasis as to somewhat distort the purity of the results. These factors, as earlier discussed, were transportation where, in the current period (Phase II), a more personalized and less time consuming service was provided; management and structure, where single management of the total activities involved in the screening process may have offered some efficiencies in performance over Phase I; and the relationship between the mother and the screening process, where, in the Phase II mode, the mother may have felt more involved and better informed about the results. If all three of these factors, as modified, presented an improvement in perception of the convenience and efficacy of the EPSDT program, the neighborhood lines of word-of-mouth communication would have acted in Phase II to produce a better community response to the program, as measured by previous rates of participation.

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[1] (This is an unduplicated count rate). It pertains to children on eligibility rosters on two specific dates (Dec.31,76 and Jun.30,77) who had entered the program by keeping a screening appointment in the preceding twelve months. It is, at this time, the most accurate of "participation" rates being used. Literally, all other operational program participation rates contain many duplicate screens including multiple infant screens, screens and rescreens of those no longer eligible, etc.

It is difficult to quantify the impact of these three factors themselves on the improved performance rates previously cited and discussed. The project staff has estimated that approximately two-thirds of the improved rates should be directly attributed to the increased availability of health services, and one-third to the other factors discussed above, i.e., more responsive transportation, single management, and improved identification between the mother and the screening process.

A method of delineating the impact of these three factors on the results, and of the result of increased availability of health services in itself, would be for the City of Dallas to take over these sites and conduct a similar test. In this manner, the three shifting variables, transportation, etc., would be restored to their earlier configuration.

Another, and programmatically better interpretation of the results, would be to state that a "package of case finding methods", consisting of in-the-home/face-to-face client contact by CSA II level case finders (community identified), offering clients an EPSDT program wherein screening sites would be located in the immediate neighborhood (generally no more than an average of ten blocks from home) and to which transportation would be provided so as to assure that the whole process would not consume more than two or three hours will produce rates of screening appointments kept in the order of 74%, and client program participation rates in the order of 60%-70% (if at least three appointment efforts are made to achieve a "kept" appointment).

(8) Conclusion

The materially improved accessibility of health services (screening sites) has a significantly beneficial impact on client participation in the EPSDT program.

In this instance, an increased availability of screening sites by a ratio of approximately seven to one was a major factor in an increase in the kept appointment rate from 51% to 74% (after three appointment sequences) and, concurrently, the population participation rate from 51% to 60%.

Increased program costs (case finding and screening) for duplicating this approach should be most minimal in the urban centers in which screening teams are already operating out of one or several established (fixed) screening sites; the objective must be to reduce the distance from the clients' homes to the screening sites to the minimum. In this project effort, the reduction was from approximately 55 to eight/ten city blocks. Donated space for clinic sites was used in all instances and community organizations were generally anxious to cooperate. If, as in Dallas, the screening team is already moving to a limited number of sites, additional sites only increase, to some minor degree, travel time and travel costs. Experience in Dallas indicates that the screening team can move and transport equipment in a recreational type van.

In this project the average cost per screen was $35.05[1] for the period of January 1977 to June 1977. (More specific cost detail is found in Chapter 5.)

2. Use of Specialized Screening Clinic for Young Adults (13-21)

a. Antecedents

Since the EPSDT program's inception the young adult component (13-21) of eligibles (0-21) has only participated in the program at about one-third the rate of the younger age groups. This fact caused concern to the Social and Rehabilitation Service, DHEW[2] which, over the past several years, has placed a high priority in its research and development program on the "older child in EPSDT". In this context, it established the following guidelines for selection of new EPSDT projects or recasting continuation projects:

- - Different ways of reaching the older child through the school, youth organizations and clubs, probation departments, recreational organizations, special programs for the handicapped, etc.;

- - substantive content of treatment plans including identification of problems relevant to the older child; content of appropriate health education, the level of staff that should be involved, methods of case management and follow-through;

- - provisions for dealing with special problems of adolescents, e.g., alcoholism, drugs, teenage pregnancy, etc.; and the development of a coordinated plan for provision of needed services with related community resources; and

- - enlisting interest and support of voluntary organizations especially concerned with youth, the schools, and appropriate professional organizations to plan for and implement an effective program meeting needs of youth within the parameters of EPSDT objectives.

The Dallas project added an objective in its second year's continuation proposal to specifically include a young adult component that would reach the young adult through the schools; would include provisions for dealing with such special problems of adolescents as alcoholism, drugs, teenage pregnancy, etc.

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[1] Full screening team costs to include direct personal costs, costing of volunteers, travel, gasoline, supplies and equipment, proportionate share of indirect costs such as utilities, rent, back-up of clerical support, etc. It does not include case finding, case monitoring or diagnosis and treatment costs.

[2] Redesignated the Health Care Financing Administration in February 1977.

and would enlist the support of voluntary and other community organizations in developing and presenting the program. These objectives were to be amalgamated into specially designated and restructured ongoing EPSDT screening clinics to be called "Young Adult Clinics".

b. Objectives: Young Adult Clinics

The intent of these clinics was to offer an extensive program of supplemental services that would specifically address health and related social problems of young adults and promote their increased participation in the EPSDT program.

c. Evaluation

Evaluation of the effectiveness of this method of stimulating increased young adult participation in the program is to be predicated upon standing rates for measurement of case finding activities in this project, e.g., kept appointments and program participation (penetration) as well as subjective narrative analysis of the program's impact.

d. Program of Implementation

(1) Young Adult Clinic Program Content

The project sought to develop its program of supplementary services through the contributions of existing service agencies in Dallas. The context of the special clinics that emerged was that of health education in topic areas of high interest and counseling services in problem areas for many young adults such as alcoholism, drugs, birth control, teenage pregnancies, etc. The specific contributions by content and agency to these special clinics were as follows:

Topics of Health Education and Counseling	Service Agency
- - Alcoholism (in family)	Al-Ateen (a service branch of Alcoholics Anonymous)
- - Alcoholism and Drug Abuse (personal & interpersonal problems)	Co Care (Dallas County MH/MR Association)
- - Dental health	Dallas City Health Department (Dental Health Education Program)
- - Nutrition (weight control, diet, food buying and preparation)	Dallas City Health Department (Dallas City Nutrition Program)

Topics	Service Agency
- - Educational Opportunities	Dallas County Community College District (Educational Opportunities Center)
- - Family Planning (birth control)	University of Texas Health Science Center at Dallas
- - Parent Counseling (single parents)	Hope Cottage
- - Veneral Disease Control and Prevention	Dallas City Health Department
- - Job Placement, Career Counseling, Job Training	Texas Employment Commission

(2) Outreach Methods for Young Adult Clinics

Outreach for the Young Adult Clinics was accomplished by the same case finders/case monitors assigned to Sectors A and B, as was case finding for all project EPSDT activities in their respective sectors. The case finding methods were primarily in-the-home/face-to-face contact with the head of household. When in contact with a family with children aged 13 - 21, a specific screening option was offered for the older children to participate in the special Young Adult Clinics.

Additionally, specialized outreach letters, intended to appeal to the interests of the teenager, were sent to these older children in the household to independently stimulate and solicit their participation in the Young Adult Clinics. Follow-up letters were sent to the parents after the home visit to continue the effort to interest the mother and child in the special clinics (copies of these letters are attached as Exhibits 1, 2, 3, and 4).

A supplementary outreach technique employed by the project was the use of volunteer teenage contemporaries as telephone aides. These aides were utilized to call those young adult eligibles with screening appointments one to two days prior to the appointment to remind them of their appointment and encourage their attendance.

Radio spot announcements were employed to provide general coverage and information concerning the Young Adult Clinics. Dallas radio stations KNOK and KKDA aired three public service type announcements (15, 30 and 60 seconds respectively) for five days prior to each monthly clinic. The content of the announcements were determined jointly by the project and the Department of Public Welfare Technical Communications Unit in Austin. These announcements stressed the health assessment (screening) and the supplementary services available at the clinics (copies of these announcements are contained in Exhibits 5, 6 and 7).

The early conceptualization of the Young Adult Clinics envisioned a considerable outreach (case finding) effort being conducted through the schools primarily associated with the eligible young adults from Sectors A and B. This concept also included the use of young adult advisory groups and councils within each school with a high density of eligibles to assist in the promotion of the Young Adult Clinics and the EPSDT program.

During the pre-test phase of the Young Adult Clinics in October - November 1976, two major alterations in the original concept were made. One, a decision was made to open the specific Young Adult Clinics (13 - 21) to all ages of children who were members of the family of a young adult who was appointed to it for screening. The reasons expressed for this alteration in concept were that in the three pre-test Young Adult Clinics, response to the program was so low by the young adults that the project became quite concerned that they would not be able to fully utilize the screening appointment openings available at the Young Adult Clinics and, thereby, cause an underutilization of the screening personnel. The second reason offered for opening the Young Adult Clinics to all ages was that the case finders in Sectors A and B in the test phase reported that the mothers of families with teenage and pre-teenage children did not want to split the family by going to two different EPSDT screening clinics, even though the intention of the Young Adult Clinics was to free the mother from accompanying her older children (13 - 21) to screening.

The second major alteration to the original Young Adult Clinic concept was their disassociation from the schools with which the eligible young adults of Sectors A and B were associated. The rationale behind this change was that the outreach effort in the schools could not delineate between welfare and non-welfare children without causing the "labeling" of the welfare children as such if they participated in the program in the school context. No method could be found to avoid this issue.

(3) EPSDT Screening and Clinic Scheduling

The EPSDT screening for the Young Adult Clinics was conducted by the regular Dallas City Health Department EPSDT screening team which agreed to participate and to devote specified clinic days and location to the young adults.

One special Young Adult Clinic was scheduled for each month in the report period, January - June 1977.

As another result of the three pre-test clinics in October - December, 1976 a decision was made to hold all the Young Adult Clinics at one site--The A. Harris Center. The clinics were organized into a series of stations in which the actual screening steps and service agency stations providing the supplemental services were integrated. It was essential that most of the stations be afforded a reasonably high degree of privacy and anonymity. The A. Harris Center provided sufficient space to meet these requirements.

Each monthly clinic (January - June) had a screening capacity of 80[1]. Again, because of concern about full utilization of the screening team's capability, the ongoing program workers in Sectors A and B servicing eligible clients with Medicaid numbers ending in 0, 1, 2, 4, 6 and 8 (approximately 60% of the eligibles) were also authorized to appoint young adult clients to these clinics up to one-half of the capacity per clinic.

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[1] This has been the established daily screening capability level of the Dallas Health Department screening team (as staffed). In order to achieve appropriate utilization of the screening team personnel (clinic capacity) over-appointment was sanctioned to a total of 120 appointment spacesper clinic to adjust for "no-shows".

A summarization of the numbers of clinics, their available appointments, and the division of appointments between project and ongoing indicates as follows:

No. Young Adult Clinics Programmed	Screening Capacity (per Clinic)	Young Adult Screening Appts. Reserved for Proj. Clients (per Clinic)	Total No. Screening Appts Available for Project Test-Six months	Screening Appts. Available in six Month Period for Proj. Eligibles ages 13-21*
6	80*	40	240 (6 clinics x 40 appts.)	160 (240 proj. appts. x .66)

*It is assumed that a minimum of one-third of the eligible appointments will be assigned to screening of other aged children (0 - 12) in the families.

(4) Transportation

The project van, as distinguished from the normal DPW contracted transportation, was used for the Young Adult Clinics when transportation was requested.

(5) Excused School Absences

The project participated in the regular Dallas EPSDT arrangements with the Dallas Independent School District to excuse children with EPSDT screening appointments from school for that part of the day necessary to attend the Young Adult Clinics. No days lost from school were involved.

e. Results

(1) Rate of Appointments Made and Kept (show for screening rate) for Young Adult Clinics (eligibles, ages 13 - 21), Sectors A and B:

Time Period	No. Appointments Made	No. Appointments Kept	Rate of Appts. Kept
January - June 1977	157	92	59%

Discussion:

The show for screening rate for the Young Adult Clinics (59%) is quite favorable. The rate of shows for screen improved with each clinic which was indicative of its growing acceptance. Additionally, the show rate was significantly higher among those eligibles contacted by their own peers by telephone just prior to the appointment to remind them of the appointments and encourage their participation.

The rate in the preceding table includes a few second and third appointment attempts. No concentrated effort was made to reappoint first appointment "no shows" to subsequent Young Adult Clinics. Subsequent appointments were often made to other regular City of Dallas EPSDT clinics.

The first appointment made and kept rate for the Young Adult Clinics was 55%. This, in itself, compares most favorably with other "first appointments kept" rates.

(2) Rate of program participation (penetration rate) for young adults 13 - 21 in Sectors A and B in two periods of time.

	Number of Eligibles				Annualized Proj. Shows for Screen		Annualized Avg. Projected Case Finding FTE's Available
	In Sectors A & B		Who Showed for Screen				
Time Period	As of Dec.31/76	As of Jun.30/77	As of Dec.31/76	As of Jun.30/77	No.	(Pen. Rate)	
Aug.76-Dec.76	802	////////	99	////////	237	29.6%	1.92
Jan.77-Jun.77	////////	712	///////	101*	202	28.4%	2.52

*There is a slight difference between this "Kept appointment" number and that reported in the previous table. This is the result of two different data sets that are not fully linked.

These data indicate that there was no impact on improving the eligible population (13 - 21) participation rate in the EPSDT program. The total potential for improving the penetration rate was limited by the number of clinics (six), the splitting of appointments between ongoing and project, and the inclusion of children aged 0 - 12 in the Young Adult Clinics. If all appointments made had been kept, the highest annualized penetration rate that could have been attained was approximately 45% (160 appointments available for ages 13 - 21)x 2 = 360 ÷ 712 (average 13 - 21 population) = 45%).

f. Conclusions

The statistical data, per se, indicates that the intent of the Young Adult Clinic test to increase the participation rates of young adults in the EPSDT program was not realized.

Though little impact in terms of increased rates of participation can be demonstrated, other criteria to evaluate the value of this approach should be considered. An assessment of the attitudes of the participating agencies toward this mode of EPSDT for young adults was conducted by the project. A review of this survey indicates that the agencies themselves were ambivalent in assessing the impact of the services they offered, in the overall, to the young clients that attended the clinics.

It would appear, however, that most of these agencies viewed the Young Adult Clinic concept as potentially productive if attendance at the clinics could be increased.

In a subjective sense, it should perhaps be concluded that the Young Adult Clinic had a beneficial impact on the young people it had contact with, but that the expense, measured in terms of manhours committed by the participating agencies and project personnel, was not justified by the numbers involved in this instance.

These results were, in many ways, pre-determined by the pre-test decisions to (1) disassociate the case finding aspect of this activity from the schools attended by the greater proportion of the eligibles (13 - 21) in Sector C, and (2) to open the clinics to all children (0 - 21) of the families of which the young adult was a member.

As earlier indicated, there were substantive reasons for these alterations to the Young Adult Clinic concept. The overriding concern about possibly "labeling" the young adults among their peers in the school environment as "welfare cases" seemingly precludes the school associated EPSDT model from further consideration. This would be unfortunate indeed, for the school associated EPSDT model, as a voluntary mode, offers the greatest potential for low cost, high rates of participation by the EPSDT eligibles 13 - 21 and 6 - 21. There are instances, however, where the school model, in one form or another, has worked without the risks of "labeling". This has been in the context of several EPSDT projects funded by SRS/DHEW, i.e., Cuba, New Mexico and Contra Costa County, California, in which waivers for participation of the non-AFDC components of the respective target populations were an integral element of the project (test). In these instances, the Federal project funds paid for the EPSDT participation of the non-eligible group and the project and State/Federal Medicaid match funds paid for the AFDC or categorical eligibles. The inclusion of all children as eligibles avoided the issue of "labeling".

The point of this discussion is that the issue of labeling can be avoided and the school model utilized if an alternative is developed that would preclude the assumption that a participant in the EPSDT program was necessarily "on welfare". Such an alternative could be to make the program available to all children in the schools, but charge a fixed fee or scaled fee relating to the cost of the screen ($30.00, for example) on an ability of parents to pay basis. This program should contain provisions for cash payments, insurance claim payments (parent/family coverage) and Medicaid coverage, with "collections" at a private station at the screening site. This approach would preclude the act of participation in EPSDT as being solely "welfare" identified by school peers.

A great deal of effort was committed to the planning and execution of this Young Adult Clinic test by the project and participating agencies. Though perhaps not of itself conclusively successful, much of value has been learned. A similar EPSDT test should be attempted with an absolute link to the schools and, preferably, with screening and some minor treatment being accomplished at the schools by mobile teams, in which all children are offered the opportunity to participate.

3. Use of Combined Case Finders/Case Monitors

Sector A vs B - Same time period - Compares two categories combined case finders/monitors PWWI-CSAIII. (Different skill levels)

Sector A/B vs A/B - Two time periods - Compares separate vs combined case finders/monitors.

Sector A vs B - Same time period - Compares two different CM/CF techniques with combined CF/CM.

a. Antecedents

Previously in Sectors A and B (Phase II, August 1976 - December 1976), separate full-time case finders and case monitors of different skill levels were employed. The pattern of investigation was to use these different skill levels employing essentially the same case finding/case monitoring techniques to determine which skill level was the most cost effective. The case finding technique was in-home/face-to-face contact with EPSDT eligible clients. The finding was that in case finding, the Public Welfare Workers I were slightly more cost effective (15%) than the lower classified/lower paid Community Service Aides II at designated levels of client participation in the program.

The outcome in the case monitoring area of evaluation was non-conclusive as shortly will be discussed.

The sequel to this was to test combined case finders/case monitors for cost effectiveness. There were several reasons for taking this course of action. One, the workers themselves (case finders/case monitors) believed they could be more effective as case monitors if they could follow a child from the start (outreach) to finish (follow-up) through the EPSDT system rather than have the case finder turn the child over to another worker (case monitor) in the moddle of the process if a health problem requiring treatment was found in the screening process. Two, there were strong indicators that the mother would respond more favorably in the follow-up process if she were associated with one rather than two case workers. Three, and of equal concern, full-time case monitors, particularly in Sectors A and B were not being effectively utilized because of the unexpectedly low problem referral rate (10%) found in the children screened by the City of Dallas EPSDT Screening Team. This factor contributed significantly to the exceedingly high and programmatically unacceptable case monitoring costs averaging $150 per health problem/immunization completion.

The impact, if any, of the combined case finder/case monitor over the separate full-time case finders and case monitors should be expected to occur beyond the point at which the second worker (the case monitor) was previously introduced, i.e., rates of "shows for treatment" and "problem/immunization completion", as well as in reduced costs per unit of such activity.

b. Distribution of Time Between the Case Finding and Case Monitoring Functions

The distribution of time to major areas of activity of the project combined case finders/case monitors (Sectors A and B) during the period January - June 1977 was generally as follows, as reflected by workers' weekly time sheets:

Project Case Workers
(Sectors A & B)

Function/Activity	Distribution of Time by percent of total time available
Case Finding	62.9%
Case Monitoring	34.5%
Orientation & Training	.0%
Administration & Management	2.6%
	100.0%

The distribution of time to these same activity categories by ongoing[1] combined case finders/case monitors in Sector D (control) was generally as follows for the same time period, as reflected by the workers' weekly time sheets:

Ongoing Case Workers
(Sector D)

Case Finding	51.1%
Case Monitoring	44.4%
Orientation & Training	3.5%
Administration & Management	1.1%
	100.0%

c. Test Objectives

Determine the relative cost effectiveness of:

(1) two different skill levels, PWW I's[2] and CSA III's[3], as combined case finders/case monitors employing essentially the same job techniques (A vs B in the same time period from February 1977 - June 1977).

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[1] The regular DPW EPSDT program workers

[2] Public Welfare Worker I

[3] Community Service Aide III

(2) separate full-time case finders and case monitors compared with combined case finders/case monitors of the same skill levels (PWW I's) employing essentially the same job techniques (A/B vs A/B in two separate time frames, August 1976 - December 1976, and January 1977 - June 1977).

(3) two different case finding/case monitoring techniques, in-home/face-to-face and letter/telephone/face-to-face, utilized by the same skill level of workers (PWW I) in the same time period (January - June 1977).

d. Evaluation - Effectiveness Measurement Rates

A vs B (same time period) Two Different Skill Levels (PWW I - CSA III Combined Case Finder/Monitor

Case Finding Component

Rate of family contacts
Rate of screening appointments made and kept
Number of shows for screen and cost per show for screen

Case Monitoring Component

Number and rate of shows for treatment
Number and rate of problem and immunization resolutions

A/B vs A/B - Separate Full-time Case Finding and Case Monitors (two time periods) with Combined Case Finder/monitor

Case Finding Component

Rate of family contact
Rate of screening appointments made and kept
Number of shows for screen and cost per show for screen

Case Monitoring Component

Number and rate of shows for treatment
Number and rate of problem and immunization resolutions

A vs D (Same time period) - Two Different Techniques of Case Finding/Monitoring, same skill (PWW I) and Combined Activities

Case Finding Component

Rate of program participation (shows for screening)

Case Monitoring Component

Rate of shows for treatment

e. Case Finding/Case Monitoring Techniques and Worker Skill Levels

The case finding/case monitoring techniques employed in these comparisons, A vs B, A/B vs A/B, and A vs D, are essentially the same as in Phase I/II, and are described in detail in the Phase II Evaluation Report (February - December 1976) dated May 15, 1977. In general terms, the case finding and case monitoring techniques in Sections A and B are highly personally oriented with most client contacts intended to be face-to-face/in-the-home. The Sector D techniques are more in the context of a phased approach, first using letters as the ways and means of contact, then secondly, using the telephone to contact those not successfully recruited in the first phase and, thirdly, using personal in-the-home encounter only to contact those not successfully recruited into the program by the first two approaches.

The worker skill levels employed, PWW I's in Sectors A and D, and CSA III's in Sector B, classification prerequisites and salary levels are also described in detail in the Phase II Evaluation Report. In general terms, the PWW I is at least a college graduate and the salary range is from $10,176 - $13,248, the CSA III requires a minimum of a high school education, is most often indigenous to the assigned catchment area, and the salary range is from $8,076 - $10,176 per annum.

The time commitment by project and ongoing workers to the respective functions was reported earlier in this discussion.

Results

Sector A vs B Comparison - Same Time Period

(PWW I's and CSA III's as combined case finders/monitors employing the same in-the-home/face-to-face contact techniques.)

(1) Rate of Family Contacts by Time Period by FTE of Case Finding Effort in Sectors A & B

Worker Category	Time Period	Sector	Number of Family Contacts	FTE's	No. of Family Contact Per CF FTE	Family Contacts Per FTE			Average Cost Per Family Contacted
						Per Mo.	Per Week	Per Day	
PWW I CF	Aug-Dec. '76 (5 Months)	A & B	252	1.92	131.25	$\boxed{26.25}$	5.04	1.01	$51.23
PWW I CF/CM	Jan-June '77 (6 Months)	A	138	1.26	109.5	$\boxed{18.3}$	4.2	.87	$85.59
CSA III CF/CM	Jan-June '77 (6 Months)	B	208	1.27	163.8	$\boxed{27.3}$	6.3	1.30	$45.75

Discussion

The significant decline in the number of family contacts for FTE by time period in Sector A in itself would appear to indicate that the combined CF/CM is not as productive in this area of activity as the full-time case finder. The lower contact performances in Sector A is, at this point in the analysis, not definable, but is later when other performance measurement criteria are applied. There are roughly the same number of families per sector (approximately 500 each) and, as of January 1977, the starting point of this phase, only approximately 25% (or 125) of the total families in each sector had been previously contacted. Analysis does indicate a slightly larger family structure in Sectors A over B (2.87 children per family vs 2.64 children per family; more children may be represented in a given number of representative family contacts.)

(2) Number and Rate of Screening Appointments Made and Kept, 1st, 2nd, & 3rd Appointments by Time Period in Sectors A & B

Time Period	Worker Category	Sector	Number of Children Apptd. for Screening	Number Keeping 1st Appointments	Rate Keeping 1st Appts.	Number Appointed Keeping 2nd Appts.	Cumulative Rate Keeping 1st and 2nd Appts.	Number Appointed Keeping 3rd Appt.	Cumulative Rate Keeping 1st, 2nd & 3rd Appts.
Aug-Dec. '76	PWW I CF	A & B	613	272	44%	87	59%	26	63%
Feb-June '77	PWW I CF/CM	A	384	173	$\boxed{45\%}$	57	60%	40	$\boxed{70\%}$
Feb-June '77	CSA III CF/CM	B	517	224	$\boxed{43\%}$	69	57%	42	$\boxed{65\%}$

Discussion

The rates of appointments made and kept are good in both instances and are so similar as to offer little distinction. The primary measurement demonstrating performance differences is the earlier rate of family contacts per FTE (1, above).

(3) Gross Number of Shows for Screen and Cost per Screen, by Sector February 77 - June 77

Time Period	Worker Category	Sector	Gross No. of Shows For Screen	Cost per Show For Screen	Ave. CF FTEs	Show per Screen per CF FTE
Aug-Dec. 77	PWW I CF	A & B	387	$25.58	1.92	202
Feb-June 77	PWW I CF/CM	A	369	$32.01	1.26	292
Feb-June 77	CSA III CF/CM	B	260	$36.60	1.27	204

There is no direct linkage between Tables 1 and 2, which are derived from the family contact forms, and Table 3, which is derived from the screening forms. The family contact sequence, as reported, is largely complete unto itself in this time period. However, many of the screens indicated above are the results of family contacts initiated in the earlier time period. Indicative of this is the fact that, in the previous report period (August - December 1976), 353 children were initially appointed for screening in Sector A, whereas only 275 were initially appointed in Sector B.

In the overall, the evidence in the case finding area in this instance is that the difference in cost per family contact (Table 1) and the differences in shows for screen (Table 3) between the two categories of workers counterbalance each other when the respective volume of activity in each is computed.

(4) Number and Rate of Shows for Medical Treatment by Time Period in Sectors A and B

Time Period	Worker Category	Sector	No. of Medical Problem Referrals	No. of Medical Problems Referred Reaching Trtmt.	Rate of Shows for For Trtmt.	Average No. of Case Monitoring FTEs Available	No. of Shows for Trtmt. per Case Monitoring FTE
Aug-Dec. '76	PWW III CM CSA III CM	A B	37	33	89%	.79	41.77
Feb-June '77	PWW I CF/CM	A	34	28	82%	.46	60.87
Feb-June '77	CSA III CF/CM	B	10	6	60%	.26	23.08

Discussion

The number of health problems identified for tracking (case monitoring) is Sector B are insufficient to be a valid comparison of skill level performance in this area of activity.

(5) Number and Date of Problem and Immunization Resolutions by Time Period in Sectors A and B

Time Period	Worker Category	Sector	Medical Referral		Immunizations		Total Medical Referrals and Immun. Needed	Total Medical Referrals and Immun. Compl.	Rates of Medical Referrals and Immunizations Compl.	Average No. of Case Monitoring FTE's Available	Number of Complete Medical Referrals & Immun. Compl. per FTE
			Made	Completed	Needed	Completed					
Aug-Dec. '76	PWW III CM CSA III CM	A B	37	37	67	5	104	42	40%	.79	53
Feb-June '77	PWW I CF/CM	A	34	27	26	3	60	30	50%	.46	65
Feb-June '77	CSA III CF/CM	B	10	6	16	2	26	8	30%	.26	31

Discussion

The difference in performance in immunization follow-up is not sufficient to justify a comparison conclusion.

Medical referral follow-up, in itself however, is good in that 86% of the total problems have had action completed on them.

Immunization follow-up, on the other hand, is ineffective in achieving any significant improvement in the rate of "complete for age". This condition prevails, notwithstanding conscientious efforts by case workers to follow up with mothers to complete immunization series consistent with the age of the child.

Conclusion

On the basis of these data, there is no distinction in cost effectiveness between the CSA III's and PWW I's as combination case finder/case monitors when all facets of job performance are appropriately considered.

Although the CSA III's were more intensely involved than the PWW I's in new family contact efforts in this report period (Table 1), the PWW I's were more concerned with follow-up contacts (from the previous report period) to reflect a greater number of "shows for screen" (Table 3). When the respective case finding units of activity (volume) were related to the unit costs, these differences counterbalanced each other. In other case finding measurements, there was no essential difference in performance between the two categories (Table 2).

The data as related to case monitoring functions (Tables 4 and 5) are essentially non-conclusive because of an inadequate sample size.

Follow-up (case monitoring) of preschool children to achieve an improved status of immunization completion after they have completed the screening process has been frustrating and ineffective. As stated in the previous report (II), means must be found to take the immunization procedure to the people--neighborhoods, homes, etc., if a significant improvement in the rate of immunization completion/currency is to be accomplished.

g. Sector A/B vs A/B Comparison - Two Time Periods (Combined Case Finder/Monitor, Compared with Full Time Case Finders and Monitors of Similar Skill Categories Employing the Same Techniques)

Discussion

There is no clear cut comparison in this context at the same skill level of full-time case finders and case monitors and combined case finders/monitors. When there is a clear comparison at the same skill level, it is only in either the case finding or case monitoring component, not in both. This may be illustrated as follows:

SECTORS

	A		B	
Time Period	Case Finding	Case Monitoring	Case Finding	Case Monitoring
Aug-Dec. '76	PWW I (Separate)	PWW III (Separate)	PWW I (Separate)	CSA III (Separate)
	↖ Same Skill ↘		↗ Same Skill ↙	
Jan-June '77	PWW I (Combined)		CSA III (Combined)	

It is for this reason that a composite A/B comparison is made across two periods of time. This comparison would have some basis of value only if there is a very apparent discrepancy between levels of performance in the two time frames. As indicated earlier, since the major reasons for converting from full-time separate case finders and case monitors to combined case finders/monitors was to achieve more effective utilization of personnel, particularly the case monitors, and to foster a better rapport with the clients by having only one worker (combined CF/CM) in contact, rather than two (separate CF/CM), the major impact of the conversion should be in reduced costs per unit of activity (contacts, shows for treatment, etc.) and improved performance in case monitoring activities. Performance measurement in case monitoring, however, is still largely constrained by the continued low level of problem identification in general.

Overall cost and performance data in the Sector A/B vs A/B comparison for both case finding and case monitoring over the two periods of time are as follows:

Unit Cost Factor	Sector	Period of Time Aug-Dec. 76 (Separate CF/CM)	 Jan-June 77 (Combined CF/CM)
Case Finding			
Cost per family contact	A/B	$51.23	$61.63
Cost per child contact	A/B	$18.08	$22.64
Cost per show for screen	A/B	$25.68	$33.90
Rate of Family Contacts per CF FTE per month	A/B	26.25	22.67
Rate of Screening Appts. kept (3 appt. sequence)	A/B	63%	67%
Case Monitoring			
Cost per Problem and Immun. Completed	A/B	$149.87	$172.95
Rate of Problem and Immun. Completed	A/B	38%	44%

Discussion

In all areas of unit cost, the combined case finder/monitor demonstrates approximately a 15% - 20% higher cost per unit than the separate case monitor and case finder.

This is compensated to some extent by an increase in rates of performance of approximately 8% - 10% in shows for screen and problem and immunization completions.

Conclusion

These data suggest a slight cost beneficial preference for the separate case finders and case monitors. However, because of other factors earlier discussed, this is not conclusive evidence that the separate and full-time case finders and case monitors are preferable to combined case finders/monitors in an operational environment.

The combined case finder/monitor affords greater flexibility in adjusting to fluctuations in workload between case finding and case monitoring than does full-time separate case finders and case monitors, and without absolute data to the contrary, should, therefore, probably be the recommended alternative.

h. Sector A vs D Comparison

(PWW I's in both sectors as combined case finders/monitors employing different techniques, e.g., Sector A, in-home/face-to-face client contact; Sector D, in sequence, letter, telephone, face-to-face/in-home.

Discussion

The Phase II report included detailed explanation of the methodology employed by the "ongoing" (Sector D contact) combined case finders/monitors in both areas of activity.

Essentially, the project technique (Sector A) is highly personalized contact with the client (in-home/face-to-face) throughout both the case finding and case monitoring process.

The "ongoing" technique (Sector D) is personalized only when other means fail and this applies both in case finding and case monitoring. In outreach the first contact is by letter, secondly, telephone is employed (when feasible) to contact those clients who do not respond to the letter and, thirdly, a personal in-home contact is made to those not successfully recruited by the first two efforts. In follow-up, the same general methodology is employed with heavier reliance on telephones than letters and resort to home contact only when all other means fail.

The Phase II comparisons in this context related to PWW I project separate case finders and case monitors compared to ongoing PWW I combined case finders/case monitors.

The Phase II comparison of these two different techniques, in which the efforts of the project separate PWW I case finders and case monitors were equated to the efforts of "ongoing" combined PWW I case finders/monitors, indicated that the"ongoing technique"(Sector D) was as cost effective as the project technique (Sector B) at designated levels of population program participation. Projections made at that time based on the project tests indicated, however, that the maximum upper level of program participation (eligible population participation rates) by this technique may be only 50%.

The only difference in the comparison context between this period and the previous period discussed above is that both skill groups are now combined case finders/monitors.

Results

Case Finding

(1) Case Finding Annualized Rate of Program Participation (penetration rate) by Sector for the Period January 1, 1977 - June 30, 1977 by FTE of Case Finding Effort

Sector	Number of Eligibles on June 30, '77	Number of Eligibles who showed for Screening June 30, '77	Number Projected to show (Annualized)	Annualized Project Aver. FTE's Avail. (Case Finding)	Projected Number of shows Per FTE Per Annum	Projected Annualized Participation Rate	FTE Eligible Pop. Ratio
A	1,379	307	614	1.25	491	45%	1/1,103
D	1,088	243	486	.67	725	45%	1/1,623

Discussion

This table still tends to confirm the efficacy of the ongoing case finding method at the less than 50% rate. The projected number of shows for screening per FTE of case finding effort is perhaps the most significant indicator.

There are, however, several factors at work that will change the direction of performance in the respective sectors. The ongoing (Sector D) FTE to eligible population ratio has now decreased to 1/1,623, whereas it was 1/989 in the previous period. The number of "shows for screen "(of eligibles on June 30, 1977) in Sector D has dropped from 464 in the previous period of 243 and the available case finding FTE has dropped from 1.20 to .67. With these factors at play and other things remaining constant, it is inevitable that future reports will reflect a decline in the ongoing program participation rate.

Though the project FTE to eligible population ratio has somewhat improved in this time period over the last, i.e., current (1/1,103; past (1/384), the project number of shows per FTE per annum has remained relatively constant (470 - 490). This may indicate that the potential range of program participation through this mode of case finding without the added incentive of highly accessible screening sites may be in the area of 45% - 55%.

(2) Case Monitoring

Rate of Shows for Medical Treatment, Sectors A and D for Period January 1, 1977 - June 30, 1977 by FTE of Case Monitoring Effort

Sector	No. of Medical Problem Referrals	No. of Prob. Refs. Reaching Trtmt.	Rate of Shows For Trtmt.	Average No. of FTE's Available (Case Monitoring)	No. of Shows for Trtmt. Per Case Monitoring FTE
A	34	28	82%	.46	60.87
D	7	6	86%	.39	15.38

Discussion

The numbers involved in this comparison are too small, particularly as related to Sector D, to draw any valid conclusions. Most importantly, both techniques presumably represent good follow-up (case monitoring) results as indicated by the rate of shows for treatment.

(3) Costs

(a) Case Finding Costs* Per Show for Screen by Two Groups of Case Finders/Monitors (Sectors A and D) of the Same Skill Level in the Same Time Period Using Different Techniques

Time Period	No. of Shows** For Screen		Total Costs Attributable to Case Finding		Case Finding Cost per Show for Screen	
	Sectors		Sectors		Sectors	
	A***	D****	A	D	A	D
Jan. 77/ June 77	369	271	$11,812	$8,412	$32.01	$31.04

*Adjusted to reflect only that part of worker time attributable to case finding.

**The difference in the number of shows for screen between this table and Table 1 is that these are the total of all screens done by sector and time period, whereas those in Table 1 are only those screens of those still program eligible at the end of the report period.

***In-home/face-to-face contact.

****Sequential: letter, telephone, in-home/face-to-face.

(b) Case Monitoring Costs Per Show for Medical Treatment By Two Groups of Case Finders/Monitors (Sectors A and D) of the Same Skill Level in the Same Time Period, using Different Techinques

Time Period	Total of Shows for Medical Treatment		Total Costs Attributed to medical problem Case Monitoring*		Case Monitoring Costs per show for Medical Trtmt.	
	Sector		Sector		Sector	
	A	D	A	D	A	D
Jan. '77 - June '77	28	6	$3,943	$3,604	$140.82	$600.67**

*This represents 55% of the total of case monitoring costs. It is assumed, based upon other information, that 45% of case monitoring time is devoted to dental follow-up.

**This should not be considered a representative cost based upon this small number of "shows for treatment."

Discussion

Though the "ongoing" program may be somewhat over committed in time and dollars to case monitoring (Table 4 above), this result is again distorted by a uniquely low medical problem referral rate, making the result basically inconclusive. To a more moderate degree, this is also applicable to the project costs. A $140 cost per show for treatment would not be acceptable in any major ongoing program.

Conclusion

The "ongoing" method of combined case finding/monitoring emphasizing sequential contact through letters, telephone, and in-home visits still continues to reflect a better cost effectiveness, particularly in the case finding components, than the project's highly personalized in-home/face-to-face method. This, however, may only be true at program participation rates below the 50% level.

Chapter III

CASE MONITORING

Test Objective

The major activity in case monitoring in this report period was to determine the impact of introducing a structured case monitoring (follow-up system) into an EPSDT program that essentially had been without one.

Secondary efforts were to evaluate the relative effectiveness of:

a. Combined case finders/monitors of the same skill level employing different techniques (A vs D).

b. Separate vs combined case finders/monitors (C vs A/B/D).

Schema for Project Case Monitoring

The schema for testing the secondary activities in the project indicated above is as follows:

SCHEMA

Case Monitoring Project Activities
January 1977 - June 1977

SECTORS

Time	Project Plan	A	B	C	D
Jan. '77	III	Separate CM (PWW III) Modify	Separate CM (CSA III) Modify		
Feb.	III	Combined Case Finder/	Combined Case Finder/	Continue Separate	Continue ongoing
Mar.	III	Monitor PWW I * Same Technique	Monitor (CSA III) *	(Full-Time) Case Monitor	Combined Case Finder/
Apr.	III		Same Technique	(WST II) * Same Technique	Monitor (PWW I)
May	III				Same ** Technique
Jun.	III				(Vertically)

*Primarily personal contact through in-home/face to face contact.

**Primarily letter, sequential telephone call (if letter is unsuccessful), sequential in-home/face-to-face contact (if letter and telephone contact unsuccessful).

Case Monitoring Work Load

The work load that has been generated in the project area for follow-up is as follows:

Case Monitoring Work Load by Sector in Two Periods of Time

	Number of Children Screened			Units of Follow-up Activity								
	Children Screened			Number of Health Problems to Resolve			Number of Children with Immunizations Incomplete			Number of Children with Dental 1st Appointment To Consumate		
Sector	Feb.-Dec. '76	Jan.-Jun. '77	Total	Feb.-Dec. '76	Jan.-Jun. '77	Total	Feb.-Dec. '76	Jan.-Jun. '77	Total	Feb.-Dec. '76	Jan.-Jun. '77	Total
A	463	369	832	55	39	94	54	32	86	UTILIZES 45% OF CASE MONITORING AVAILABLE EFFORT**		
B	371	260	631	10	11	21	42	17	59			
C	699	470	1169	87	54	141	54	34	88			
D	527	271	798	72	16	88	NO DATA*					
Total	//////	//////	3430	//////	////	344						

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* The "ongoing" DPW case workers do not monitor incomplete immunizations.

** Numbers are not available because of the separateness of the dental program. (See following narrative for more detailed explanation).

The work load generated by the screening volume is in all aspects remarkably low, i.e.,

a. Health Problems

Health problem referrals are identified in only 10% of the total screens (344 problems out of 3,430 screens). This is almost three times less than the overall State EPSDT problem referral rate (28.4%).

b. Immunization Incompletions

The data suggests that 77% of all children screened (0-6) in

Sectors A, B, and C[1] have immunizations complete for age at the termination of screening. Such a high rate of completions is quite unique. The extreme difficulty in achieving any significant improvement in the 23% incompletes by intensive follow-up suggests that the 77% should be further scrutinized to determine if any systematized erroneous clerical/data entries are being made.

Distribution of Case Monitoring Work Effort

Special sample studies of worker time commitments, both ongoing (Sector D) and project (Sectors A, B, and C), indicate that approximately 45% of the total time spent in case monitoring is committed to follow-up to achieve a successful "kept appointment" for a first dental visit for examination and limited treatment.

The Texas Title XIX dental program for children is unique among the States in that it is separate from the EPSDT program. This delineation includes overall program management and operation, forms, forms flow, budgeting evaluations, etc. In this configuration of separateness, the Dallas project was not proposed to include the dental program. Consequently, it was not designed to collect data and execute evaluation of the interrelated components of the Texas Title XIX dental program. Notwithstanding, as the eligible Title XIX population (EPSDT eligibles) was divided in the project area between the ongoing program and the project, rather than held intact as project clients, the project EPSDT workers were required to execute case finding and follow-up for both the Title XIX dental program and the EPSDT program to almost the same degree as the ongoing workers. As previously indicated, approximately 30% of case finding activities and approximately 45% of the case monitoring activities are committed to the dental program. This information is important for an understanding of the division of full-time equivalents to various functions and developing associated program costs.

Evaluation Effectiveness Measurement Rates

The rates to be utilized in the measurement of the major activity (pre- and post-case monitoring system) are identified separately in the discussions of that test that immediately follows.

The rates to be utilized in the measurement of the secondary activities, i.e., combined case finder/monitor using different techniques (Sector A vs D) and separate vs combined case monitors (Sector C vs A/B/D) are as follows:

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[1] Eighty-three out of 362 children (0-6) screened in Sectors A, B, and C in the period January - June 1977 had incomplete immunization sheets.

	Rate	Formula		
1.	Rate of Problem Completions (Single problem)	$\dfrac{\text{\# Confirmed problems resolved (completed)}}{\text{\# Confirmed problems (by sector/type case monitor)}}$	=	Rate of problem completions by sector/type case monitor
2.	Rate of Immunizations (current for age)	$\dfrac{\text{\# Immunizations current for age at end of 150 days (for demon.)}}{\text{\# Immunizations not current for age at point of entry to initial visit (shows for screen)}}$	=	Rate of Immunizations completed (sector/month)

Evaluation of Variables

Following is the evaluation of the three case monitoring variables tested in this report period:

1. Introduction of a Distinct Case Monitoring (Follow-up) System

a. Antecedents

In the early stages of EPSDT program development, the link between screening and treatment (of problems found in screening) was tenuous at best in many States. It is because of this that the EPSDT program had frequently been castigated as a screening program without real purpose.

The historical development of "EPSDT" almost, in a sense, pre-ordained this "weak" linkage. EPSDT emerged as an entity in many States following traditional roles and responsibilities. This rather extensively employed "de facto" model found overall program responsibility and the function of case finding (outreach) clearly placed in the States' Departments of Public Welfare/Medicaid Agency and the screening function contracted by the Department of Welfare to the States' Health Departments. Problems found in the screening process were most often referred to the private sector of health for diagnosis and treatment but it frequently was totally unclear as to who had responsibility to follow up (monitor) the referral to reasonably assure its accomplishment.

Traditionally, the case finding function (program outreach) was a recognized welfare department role for the programs it administered, such as family planning, protective services for children, food stamps, foster care, etc. Case finding for EPSDT fell readily into this pattern. The case monitoring (follow-up) of health problems of the poor had traditionally been a public health function. In most instances in the program's early stages, the contract between the States' Departments of Public Welfare and Health for the EPSDT program only provided for "screening" per se. If follow-up (monitoring of cases) was to be accomplished, then by omission from the contract to Health, it fell upon the agency with the overall program responsibility. This was an unaccustomed role for welfare departments and, as a consequence, in the first phases of the EPSDT program's development, often little was done to follow up on problems found in the screening. Frequently, it appeared that the welfare agency was not aware of the requirement to execute follow-up (monitoring). In this instance the program was, as alleged, a screening mill with little beneficial value. Over time, with the Social and Rehabilitation Service increasingly stressing the requirement for follow-up, the States (Department of Public Welfare) came to recognize and give identification to this role. Frequently they assigned the responsibility for assuring the child an opportunity to be treated (case monitoring) as an additional function to social service workers (case workers) already on the rolls providing general social service program assistance. In general, these same workers had already been given the case finding function for the EPSDT program as an additional responsibility.

In some instances, even today, States have not fully identified and appropriately assigned the "follow-up" function. This situation was identified as recently as March 1977 when, under contract to SRS/DHEW, this Institute completed its findings of a survey of the case-monitoring status of the EPSDT program in nine states.[1] It is significant, however, to note the improvement in this situation over time. This Institute conducted a similar study of eight States for the SRS/DHEW in 1973[2] and found a show for treatment rate of 46.1% for problems found in screening.

The Subcommittee on Oversight and Investigations of the Committee on Interstate and Foreign Commerce of the House of Representatives, based upon a mail survey it conducted of States, which reflected available State data for late 1974 and early 1975, reported 60.4% reaching treatment.[3]

In 1976, in order to obtain more current information concerning the EPSDT program's effectiveness, SRS contracted with this Institute to conduct the Nine States survey previously cited. This survey was conducted from October 1976 to February 1977 and covered nine States with 44% of the total program eligibles in the United States. This survey found that in the overall, 78% of children with problems found in screening reached treatment for at least one problem and that 72% of the problems reached treatment.

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[1] Review of Shows for Treatment - EPSDT - A Nine State Survey, Health Services Research Institute, The University of Texas Health Science Center at San Antonio, March 31, 1977.

[2] Information Memorandum, MSA-IM-74-11, Medical Services Administration, Social and Rehabilitation Service, DHEW, February 21, 1974.

[3] Department of Health, Education and Welfare's Administration of Health Programs: Shortchanging Children: Report of the Subcommittee on Oversight and Investigation of the Committee on Interstate and Foreign Commerce, House of Representatives, Ninety-fourth Congress, Second Session, September,1976

Two conclusions of the Nine State Survey that are of significance to this situation were:

> ". . . Program performance, and particularly State level cognizance of the follow-up treatment provided children with problems found in screening, was significantly better in jurisdictions which recognized follow-up (case monitoring) as a specific function of the EPSDT program and had assigned it to a specific State agency.
>
> . . . The combined public sector screening/private sector treatment referral (the "two-step" approach) can be as effective at follow-up for treatment as the single setting "private sector screening and treatment" (the "one-step" approach), if a sound system of case management is in effect. This statement is made without consideration of the total costs of each approach, which are still largely unknown."

The improving rates of "shows for treatment" over time is largely due to the definitive placement of the case monitoring (follow-up) responsibility within the States and the development and implementation of sound systems of case management (follow-up).

It was in the context of the information available from the 1973 survey indicated above with its 46% show for treatment performance that the Dallas project concept for case monitoring germinated. SRS had published its conclusion[1] based on that survey that:

> "Follow-up on positive screens remains the most important program component to emphasize . . . The most important element in getting a high percentage to treatment seemed to be the clear explanation to the parent of what was wrong and where to take the child, along with the assignment of a point of responsibility for follow-up in each screening center or each locality. It is further recommended that a formalized system of patient referral (with a referral log and feedback form) be used for case management . . ."

In this same time frame, the Health Services Research Institute began the design of a model EPSDT system for use in evaluation of EPSDT projects. It included a five subsystem classification of EPSDT with a close-ended data system to track all children entering the program from point of initial contact to problem resolution. This modular approach was described in an EPSDT Demonstration Model-Evaluation Handbook, first published by the Institute on September 1, 1974, field tested and republished in a second version dated May 1, 1975. The case monitoring control form and system were introduced into the Dallas project in February 1976 in a modified version to more closely parallel a similar system being developed for introduction in the State of Texas.

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[1] Information Memorandum, MSA-IM-74-11, February 21, 1974.

In conjunction with the State, it was mutually agreed that the project use of the case monitoring system would be a pre-test for the Texas system overall. There was, however, one major philosophical difference between the project and the State case monitoring concepts. The project system was designed to follow a problem to final treatment resolution or administrative termination. The State system was intended only to track the problem (child) to a treatment provider (a show for treatment). This latter approach more closely identifies with the EPSDT Federal guidelines and penalty regulations.

The project approach, however, was more classically health outcome oriented, looking toward treatment completion rather than just the process count of shows for first treatment.

In order to resolve the two objectives, it was agreed that the project could add a supplemental sheet to separately collect the additional data. Copies of the basic and supplemental forms are attached as Exhibits 8, 9, and 10. The State imposed the stipulation, however, that any data beyond that in the basic problem referral form could not come from additional inquiry of the treatment provider. These additional data had to come from the mother or other available source. The State imposed this constraint to avoid any "backlash" from the provider group about additional paper work that might endanger the prospects of approval for their system on the "drawing board", so to speak.

The major point in this narrative is that up to the time the project began (February 1976) the Texas EPSDT program did not have a distinct case monitoring (follow-up) system. The Department of Public Welfare was aware of its responsibility in this regard as is evidenced by its efforts to develop a system, then in embryo. To some extent, local Departments of Welfare case workers with multi-program responsibilities, in accordance with State program guidelines, were attempting to assist in screening referrals. State Health Department EPSDT screening activities were also advising mothers to seek treatment for their children when problems were found in screening.

This state of affairs then provided an excellent opportunity to determine the impact of introducing a case monitoring system, per se, on the show for treatment rate, and serve as an example for other jurisdictions.

The Test

The major purpose of this test was to determine the impact of introducing a structured case monitoring system upon the rate of children and problems receiving treatment (first appointment).

An additional objective was to determine the relative effectiveness of the State's process oriented case monitoring (to show for treatment) with the more extended project's outcome oriented case monitoring (to treatment completion) on the rate of completion.

Implementation

1. Impact of Introducing a Structured Case Monitoring System on Rates of Problems Receiving Treatment (First Appointment).

This test was based upon rates of "shows for treatment" in Sector D, the control sector, representing the ongoing program in two phases, i.e., (1) before the distinct case monitoring system was introduced, and (2) after it was implemented. The first phase covers the period from August through December 1975 and the second phase from May through December 1976. In both phases, random samples were selected of children who had referrable health conditions identified in the screening process.

Group I (Pre-test) represented children who were screened and referred between August and December 1975.

The case monitoring system was initiated in February 1976.

Group II (Test) represented children who were screened and referred between May and December 1976.

There were 91 problems in Group I and 109 in Group II. This sample is proportionate for the percent of problem referrals (Form 402) originated for the total populations screened during the defined time period for each group. In total, the sample of problems for both groups represents the results of over 2,000 EPSDT screens.

Follow-up of these problems was accomplished first by review of the individual client's DPW case folders for definitive information concerning treatment received and, where definitive information was not available in the case folder, by interview with the client. All clients were interviewed in Group I and 44 in Group II. Interviews were conducted by phone with the exception of home visits to those few who did not have phones. A few outcomes which remained questionable after client interviews were confirmed through interviews with the treatment provider. Information was not obtainable on 15 clients in Group I and four in Group II. Consequently, these samples were reduced to 82 children with 91 problems in Group I and 95 children with 109 problems in Group II.

The results of this test were:

Group Description	Time Period Represented	Problem Sample Size (n)	Number and Rate of Shows for Treatment	
I (Pre-Test)	Aug.-Dec. '75	91	58	64%
II (Test)	May-Dec. '76	109	93	85%

This result represents a significant improvement (33%) in the show for treatment rate by introducing a distinct case monitoring system. These results are consistent with findings from the previously cited Nine State Survey that States with established and distinct case monitoring systems could achieve "show for treatment" rates in the range of 80% - 90%. Obviously, State programs that are still less advanced than the Texas program was in the pre-test phase have a potential for much higher rates of improvement.

2. Impact of Limited and Extended Case Monitoring on the Rate of Problem (Treatment) Completion.

This test is based upon rates of problem completion between Group II previously described as limited in follow-up to "show for treatment" and a third group (III) which,as a project activity, is normally followed-up to "treatment completion".

The 76 problems randomly selected for Group III were drawn from a total of problem referral sheets (TDHR/DPW) from all three test sectors (A, B, and C) of the project for the period of February to December, 1976. These problems represent the results of over 800 EPSDT screens.

Follow-up of these problems was accomplished in the same manner as previously described, i.e., records review and, if necessary, telephone interview and home interview. No interviews with clients were necessary for Group III. Information was not obtainable on one client; consequently, the sample was reduced to 67 children with 76 problems.

Follow-up assistance by case workers in Groups II and III included suggestions concerning provider availability, treatment appointment assistance, and transportation arrangements. Both the ongoing (Group II) and project (Group III) follow-up required up to three appointment efforts to achieve a successful first treatment appointment. Project follow-up (Group III) continued thereafter for at least six months or terminated earlier if treatment was completed. At the end of six months, the project was reminded monthly by name of all cases that had not been closed for continued follow-up.

It was hypothesized that Group III would have a significantly higher rate of treatment completions than Group II.

The results of this test were:

Group Designation	Time Period Represented	Problem Sample Size (n)	Number and Rate of Completions	
II (Limited Follow-up)*	May-Dec. '76	109	79	85%
III (Extended Follow-up)**	Feb.-Dec. '76	76	53	88%

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* To show for treatment.

** To treatment completion.

Contrary to expectations, no significant difference was found in the treatment completion rates between these two groups. It may be that extended case monitoring (to treatment completion) is no more effective than limited case monitoring (to show for treatment) in achieving problem treatment completion.

The absence of significant differences between the groups may be due to the high proportion of problems in both groups that required only one treatment visit for completion, i.e.,

Number and Percent of Problems that Showed for
Treatment and Required One or More
Visits for Resolution

Group Designation	Treatment Period Represented	Problem Sample Size (n)	Number Showed for Treatment	No. of Trtmt. Visits Req. and Percent of Total Shows	
				1 Visit	2 or more visits
II Limited Follow-up	May-Dec. '76	109	93	56 60%	37 40%
III Extended Follow-up	Feb.-Dec.'76	76	60	39 65%	21 35%

Approximately 62% of the problems required only one visit to complete treatment of the problem.

It is of interest to note that of the 64% of Group I that showed for treatment, and of which only an incidental type follow-up was available, essentially the same result was obtained, i.e., 60% of the problems that showed for treatment were resolved in one visit and 40% in subsequent visits.

These results suggest that once a client enters the treatment sequence (shows for treatment), the likelihood of treatment completion is in the same order of magnitude with or without extended case monitoring.

Conclusion

Results indicate that the introduction of a distinct case monitoring system[1] into an EPSDT program offers the potential of 80%-90% of problems found in screening reaching treatment.

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[1] To include referral forms, treatment appointment assistance, transportation assistance, and provider/client feedback.

Results also indicate that limited case monitoring to "show for treatment" offers as great a potential for treatment completion as does extended case monitoring through treatment completion.

a. Use of combined case finders/monitors of the same skill level employing different techniques.

This test is covered in Chapter II, Case Finding (Sector A vs D comparison) to include the impact of the combined activity on case monitoring.

b. Use of combined case finder/monitors compared to separate case monitors.

Antecedents

In the previous phases of the project, full-time distinct case monitors of varying skill levels using the same follow-up techniques were employed in each sector (A, B, and C) to determine the most cost effective skill level of case monitoring.

The reduced level of project eligible population by 60% and the low level of referrable problems (10%) identified in the screening process acted in combination to produce such a low case monitoring work load as to largely negate the results obtained.

In an effort to counteract this imbalance in work load, the project director combined the functions of case finding and case monitoring in Sectors A and B in the same case workers. Another factor that influenced the decision to combine these functions was the worker recommendation that the family heads would respond more favorably to all aspects of the program if relating to one rather than two separate workers. In this framework, however, the combination of functions could largely only serve to improve the client response to the program beyond that point at which the second worker would previously have been introduced, i.e., the case monitoring aspects of the relationship. It should not be expected to produce any material impact in the case finding area of activity.

The Test

This test is to measure the relative effectiveness of combined case finders/monitors and separate case monitors only in case monitoring activities.

A full-time case monitor was maintained in Sector C because of the heavier case monitoring work load that resulted from the more intense case finding effort in that sector. The comparison in this instance will be Sector C (separate) compared to Sectors A and B. The test result, in any instance, could only be a basis for further examination in that skill levels differ in each sector although the case monitoring techniques were most similar.

Evaluation: Effectiveness Measurement Rates

The effectiveness measurement rates in this instance will be the rates of:

Shows for treatment

Problem completions

Immunization completions

Results

(1) Rate of Show for Treatment, Sectors A, B, and C February 1977-June 1977 Case Monitoring Component

Sectors	No. of Medical Problem Referrals	No. of Problem Referrals Reaching Trtmt.	Rate of shows for Trtmt.	Aver. No. of case monitoring FTEs Avail.	Number of Shows for Trtmt. per case monitoring FTE
A (Combined CF/CM)	34	28	82%	.46	61
B (Combined CF/CM)	10	6	60%	.26	23
C (Separate Case Monitor)	53	39	74%	.54	72

(2) Number and Rate of Problem and Immunization Completions (brought current for age), Sectors A, B, and C - February 1977-June 1977 - Case Monitoring Component

Sector	No. of Med. Referrals	Number of Medical Referrals Completed	No. of Immun. Needed	No. of Immun. Compl.	Total No. of Med. Ref. & Immun. Needed	Total No. & Total Med. Ref.& Immun. Compl.	Rate of Med. Ref.& Immun. Compl.	Aver. No. C.M., FTEs Avail.	No of Compl Units* Per FTE (C.M.)
A (Combined CF/CM)	34	27	26	3	60	30	50%	.45	67
B (Combined CF/CM)	10	6	16	2	26	8	30%	.26	31
C (Separate (Case Monitor)	53	41	30	1	83	42	51%	.39	108

*Medical referrals and immunizations.

Discussion

In both of the above tables, the number of cases in Sector B are insufficient to utilize in a comparative analysis.

In the one instance (Table 1), the separate case monitor (Sector C) appears to be minimally more effective in case monitoring activities than the combined case finder/monitor (Sector A). This is primarily reflected in the "Number of Shows for Treatment per Case Monitoring FTE" (72 over 61).

Table 2 also indicates a higher level of performance for the separate case monitor in terms of the "Number of Completed Medical Referrals and Immunizations per FTE" (108 over 67).

Conclusion

These data continue to support the conclusion expressed in Chapter II in the A/B vs A/B comparison (page 41) that there appears to be a minimal cost beneficial and operational performance advantage in the separate full-time case finders and case monitors. However, because of factors discussed in both tests, this cannot be considered conclusive evidence to this end. The combined case finders/monitors affords greater flexibility in adjusting to fluctuations in work load between finding and case monitoring than full-time separate case finders and monitors and without absolute data to the contrary,should perhaps be the alternative of choice.

Chapter IV

COSTS

In the chapters on case finding and case monitoring, rates were identified which would be used to evaluate the effectiveness of the variables being tested in the respective subsystems. The full impact of these rates, however, also has to be considered in terms of their costs. The complete expression of the rates including costs, is as follows:

Case finding

Effectiveness element	Cost element
(1) Rate of "shows for screen" to eligible population, by technique being tested, by sector	*per average cost per show
(2) Rate of "family contacts" per week, by type aide	*per average cost of contact
(3) Rate of screening appointments made to children in family contacted (sector)	*per average cost of screening appointment
(4) Rate of appointments kept (shows for screen) to children appointed, by technique (sector)	*per average cost of appointment kept

*Case finding subsystem costs divided by the average number of actions in a specific time frame.

Case monitoring

Effectiveness element	Cost element
(1) Rate of problem completions, of problem sheets initiated (by time) by type monitor (sector)	*per average case monitoring cost of problem completions
(2) Rate of case completions (of multiple problem sheet cases initiated, by time) by type monitor (sector)	*per average case monitoring cost of case completions
(3) Rate of screen completions of screening sheets initiated, by time, by type monitor (sector)	*per average case monitoring cost of screen completions

(4) Rate of immunization completions of immunization sheets not completed at screening, by time, by type monitor (sector)	*per average case monitoring cost of immunization completions

*Case monitoring subsystem costs divided by the average number of actions in a specific time frame.

All the guidelines, forms, instructions, etc., for collecting and reporting cost data by the project are included in the EPSDT Demonstration Model--Evaluation Handbook published by HSRI in May 1975. The basic cost data collection Individual Worksheet and the instruction sheet covering its preparation are included in Appendices 2 and 4 to Chapter V, Evaluation Report, Phase II, February - December, 1976, for reference.

The system devised was, to a great extent, a result of the Institute's experience in establishing cost data systems for the "old" demonstration projects (i.e., Cuba, New Mexico; Contra Costa, California; Washington, D.C.; San Antonio, Texas).

The cost elements of analysis, e.g., average cost of shows for screen, average cost of problems completed, etc., are dependent upon:

(1) accurate reporting of project employee hours by subsystem or designated major activity;

(2) accurate reporting of total costs per month chargeable to specifically designated accounts.

Direct costs, such as salaries, screens, treatments, etc., are relatively easily identified with subsystems (case finding, screening, diagnosis, treatment and case monitoring) for specific components of time (or sector).

Indirect costs, such as rent, utilities, maintenance, depreciation and administrative support (e.g., recruiting, classification, etc.) are generally not as easily identified with a subsystem. To overcome some of these difficulties, the HSRI cost system prescribes the charging of indirect costs to subsystems or major activities, based upon the percent of personnel hours committed to each subsystem.

1. Overall Costs

a. Total Project Operational Costs (excludes project overhead/management, etc.) by Major Funding Categories

Period	Average FTE's	Hours Worked	Direct Costs			Indirect Costs	Total Costs
			Personnel	Travel	Screening		
Jul. '76-Dec. '76	10.45	9,533	$60,689	$2,208	-*	$5,309	$68,206
Jan. '77-Jun. '77	11.98	11,407	$70,979	$2,953	$7,588	$5,431	$86,951

*The project was not involved in executing screening during this period.

b. (1) Total Unadjusted Operational Costs and Percentages by Functional Category

Period	Total Costs	Case Finding	Case Monitoring	Screening	Orientation & Training	Administration & Management
Jul.'76-Dec.'76	$68,206	$28,532	$23,826	0*	$4,059	$11,789
	(100%)	(42%)	(35%)	0	(6%)	(17%)
Jan.'77-Jun'77	$86,951	$31,091	$22,009	$18,868	$3,201	$11,782
	(100%)	(36%)	(25%)	(22%)	(4%)	(14%)

*The project was not involved in executing screening during this period.

Discussion

Since the functions of case finding and case monitoring are personnel intensive, there is a very positive relationship between dollars and personnel time committed to the various functions. Additionally, to appropriately arrive at unit type costs such as "cost per family contact", "cost per kept appointment", etc., it is necessary that all appropriate operational costs be charged to the operational functions of the project, i.e., case finding, case monitoring and screening. As is obvious from Tables a and b (1) above, all indirect and direct cost chargeables to the operational component of the project are appropriately reflected. Time sheets of operational workers, supervisors, and operational support personnel, however, reflect separately "orientation and training" and "administrative and management" activity (Table b) that still needs to be charged to the operational functions to develop full unit costs that would be comparable with other programs' or projects' unit costs. It is not appropriate, however, to reallocate the total 18% ($14,983) indicated in Table b above in that much of this "overhead" type cost is unique to the project.

The "ongoing" (Control Sector D) worker time sheets reflect 4.6% of total available time allocated to these two overhead type activities. This proportion of time committed to overhead functions is consistent with data from other projects and programs. Accordingly, 4.6% (.046 x 86951 = $4,000) of the total operational dollars will be sub-allocated to the operational functions in the same proportions as they otherwise occur, i.e., 43% to case finding, 31% to case monitoring and 26% to screening.

b.(2) Total Adjusted Costs and Percentages by Functional Category

Period	Total Costs	Case Finding Costs	Case Monitoring Costs	Screening Costs	Project Overhead Costs*
Jan.-June 1977	$86,951	$32,811	$23,249	$19,908	$10,983
	(100%)	(38%)	(27%)	(23%)	(13%)

*Orientation and training, administration and management unique to a project conducting research.

2. Case Finding Costs ($32,811)

a. Case Finding Costs per Family Contact by Sector and Time Period

	# Family Contacts* SECTORS				Case Finding Costs SECTORS				Costs Per Family Contact SECTORS			
Period	A	B	C	Total	A	B	C	Total	A	B	C	Total
Jan.-June 77	138	208	214	560	$11,812	$9,515	$11,484	$32,811	$85.59	$45.75	$53.66	$58.59

*From family contact records (January 1 - June 30)

b. Case Finding Costs per Child Contact by Sector and Time Period

	# Child Contacts* SECTORS				Case Finding Costs SECTORS				Costs per Child Contact SECTORS			
Period	A	B	C	Total	A	B	C	Total	A	B	C	Total
Jan-Jun. 77	392	550	537	1,479	$11,812	$9,515	$11,484	$32,811	$30.13	$17.30	$21.39	$22.18

*From Family Contact Records (January 1 - June 30)

c. (1) Case Finding Costs per Kept Appointment (Show for Screen) for Sectors A, B, and C and Time Period

	# Kept Appointments* SECTORS				Case Finding Costs SECTORS				Cost Per Kept Appointment SECTORS			
Period	A	B	C	Total	A	B	C	Total	A	B	C	Total
Jan-Jun. 77	369	260	470	1,099	$11,812	$9,515	$11,484	$32,811	$32.01	$36.60	$24.42	$29.86

*From Screening Sheets dated January 1 - June 30, 1977

(2) Case Finding Costs per Kept Appointment (Show for Screen) for Sector D (Ongoing)

Period	# Kept Appointments Sector D*	Case Finding Costs	Cost per Kept Appointment Sector D
Jan.-Jun. 77	271	$8,412	$31.04

*From Screening Sheets dated January 1 - June 30, 1977

3. Case Monitoring Costs ($23,249/$19,915[1])

As indicated in previous reports and in Chapter III, this report, 45% of the project case monitoring effort is committed to achieving a successful "kept appointment" for a first dental visit of clients approved for the separate Title XIX dental program. Dental follow-up was not intended by the State to be an element of this project's activities, therefore, the original data input design did not include dental input.

As a consequence, it is only possible to develop case monitoring unit costs related to health problems, referrals, and immunization. In order to arrive at these costs, it then is necessary to categorize the total of case monitoring costs into a "dental component" and a "health/immunization component" and then develop the health/immunization unit costs as related only to that component, as follows:

a. Case Monitoring Costs ($19,915) Distributed by Functional Category and Sector, February - June 1977

Sectors	Total Costs	Health Problem and Immunization Follow-up Costs (55%)	Dental Follow-up Costs (45%)
A	$7,169	$3,943	$3,226
B	$4,780	$2,629	$2,151
C	$7,966	$4,381	$3,585
	$19,915	$10,953	$8,962

b. Case Monitoring Costs ($10,953) per Show for Treatment by Sector, February - June 1977

	# Shows for Treatment*				Case Monitoring Costs				Costs per Show for Treatment			
	SECTORS			Total	SECTORS			Total	SECTORS			Total
Period	A	B	C		A	B	C		A	B	C	
Feb.-Jun.77	28	6	39	73	$3,943	$2,629	$4,381	$10,953	$140.82	$438.17**	$112.33	$150.04

*From problem sheet file.

**It should not be considered a representative cost based upon the small number of problems for follow-up.

---

[1] The case monitoring component of the adjusted costs from Table b (2) that covers the period of January - June 1977 is $23,249. Because the case monitoring variables in this report period changed on February 1, 1977, the total case monitoring dollars, as shown in this section, will reflect only the February through June, 1977 component of the cost,which is $19,915.

c. Case Monitoring Costs ($10,953) per Problem and Immunization Completion by Sector, February - June 1977

SECTOR	No. of Medical Referrals	Medical Referrals Completed	Immuniz. Incompl.	Immuniz Compl.	Medical Refs. & Immuniz. to be Compl.	Medical Refs. & Immuniz. Compl.	Case Monit. Costs	Case Monit. Cost Per Compl Medical Referral & Immuniz. Compls.	Rate of Med. Ref. & Immuniz. Compls.	Ave. No. of Case Monit. FTEs Avail.	No. of Completed Med. Ref.& Immuniz. Per C.M. FTE
A	34	27	26	3	60	30	$3,943	$131.43	50%	.45	67
B	10	6	16	2	26	8	$2,629	$328.63	31%	.26	31
C	53	41	30	1	83	42	$4,381	$104.31	51%	.39	108
	97	74	72	6	169	80	$10,953	$136.91	47%	1.10	73

d. Case Monitoring Costs per Show for Medical Treatment for Sector D (Ongoing)

Period	No. Kept Appointments (Medical Treatment)	Case Monitoring Costs	Costs per Kept Treatment Appointment
Jan-Jun 77	6	$3,604	$600.67*

*This should not be considered a representative cost based upon the small number of "kept appointments".

4. Screening Costs ($19,908)

Screening Costs per Kept Appointment (Show for Screen) For Sector C

Period	No. Kept Appointments Sector C	Screening Costs Sector C	Costs per Kept Appointment Sector C
Jan-Jun 77	470*	$19.908** $16,476***	$42.36** $35.05***

*From screen sheet file dated January 1 - June 30, 1977.

**Unadjusted for depreciation of supplies and training.

***Adjusted for depreciation of equipment (straight line-4 years) and allocation of training center (straight line-2 years).

These screening costs are distributed as follows:

A. Personnel	
Nursing	$6904
Clerical	2385
Volunteer	1543*
	$10,832
B. Direct Cost	
Travel	$1271
Supplies	778
Lab Fees	863
Postage, etc.	100
Doctor's consulting	950
	$3962
C. Indirect Cost	
Overhead	$ 720
Equipment	262**
Volunteer training	700***
	$1682
TOTAL	$16,476

---

*Estimated cost based on hours worked times legally established ($2.30) minimum wage per hour plus 5.85% for Social Security.

**Straight line depreciation over 4 years

***Straight line depreciation over 2 years

5. Summary of Performance Unit Costs and Related Rates, by Sector

		Sectors							
		A		B		C		D	
Period	Rate	Rate	Cost	Rate	Cost	Rate	Cost	Rate	Cost
Case Finding									
Jan.77-Jun.77	% Families Contacted (Annualized)	45%	$85.59 (per contact)	48%	$45.75 (per contact)	66%	$53.60 (per contact)	/ / /	/ / /
Jan.77-Jun.77	% Screening Appts. Kept	70%	$32.01 (per appt. kept)	65%	$36.60 (per appt. kept)	74%	$24.43 (per appt. kept)	/ / /	$31.04 (per appt. kept)
Jan.77-Jun.77	% Participation (Penetra. Rate)	45%	$32.01 (per appt. kept)	32%	$36.60 (per appt. kept)	60%	$24.43 (per appt. kept)	45%	/ / /
Case Monitoring									
Feb.77-Jun.77	% Treatment Appts. Kept	82%	$140.82 (per show for trmt)	60%	$438.17 (per show for trmt)	74%	$112.33 (per show for trmt)	///	$600.67* (per show for trmt)
Feb.77-Jun.77	% Medical Problems & Immunization Completions	50%	$131.43 (per trmt. and immun. complete)	31%	$328.63 (per trmt and immun. complete)	51%	$104.31 (per trmt. and immun. complete)	/ / /	/ / /

*This should not be considered a representative cost based upon the small number of kept appointments

Dear Ms

It's again time for your children to have their yearly checkup through the EPSDT program.

Since you have a young adult (age 13 through 20) in your family we are offering an opportunity to participate in an exciting screening program designed specially for them. They will receive information about the new Young Adult Clinic in the mail soon.

Will you please ask them whether he or she would like to go to the regular clinic or to the one especially for them?

I will contact you to discuss this and to schedule a clinic appointment.

Sincerely,

State Department of Public Welfare
230- Lancaster-Kiest Shopping Center
Dallas, Texas 75216

Exhibit 1

WHAT'S HAPPENING!

YOUNG ADULT CLINIC

Dear

Perhaps you know about the exciting new Young Adult Clinic. This is a chance for you to get a yearly physical exam. The clinic is exclusively for young adults.

While there, you also can talk to some people about things that might interest you. They can answer your questions and help you in such areas as family planning, money for advancing your education, dealing with any "hang-ups," and so on.

We would like for you to talk with your parent about this opportunity. I will be visiting in your home soon to find out if you can go to the Young Adult Clinic; I hope you will.

State Department of Public Welfare
230-A Lancaster-Kiest Shopping Center
Dallas, Texas 75216

the bump · the muscle · gett'n down ·

Exhibit 2

THANK YOU!

Dear

Thank you for encouraging ______________________________ to come to the Young Adult Clinic. The appointment is set for ________ ____________________________ at the Harris Clinic. I am sure that it will offer personalized service to help maintain good health. I hope your family likes the idea of the Young Adult Clinic and continues to support it. If I can be of further service let me know.

____

State Department of Public Welfare
230-[illegible] Lancaster-Kiest Shopping Center
Dallas, Texas 75216

P.S. Be sure to send the signed parent consent form, and the current green Medicaid card with your young adult (s) to the clinic.

Exhibit 3

Dear

I am happy you can come to the Young Adult Clinic at 210 A. Harris Shopping Center. Things are all set for your visit. Your appointment time is__________ at______________________.

I hope you enjoy talking to the people there.

We are glad to have this chance to serve you.

____

State Department of Public Welfare
230-A Lancaster-Kiest Shopping Center
Dallas, Texas 75216

P.S. Be sure you bring the signed parent consent form, and the current month's green paper Medicaid card with you.

Exhibit 4

CLIENT: YOUNG ADULT CLINIC

ANNOUNCER (30)

If you're a teenager and you need a medical exam with something personal and private--birth control, pregnancy, VD--call the Welfare Department's Young Adult Clinic, 372-4671. The Young Adult Clinic in the A. Harris Shopping Center offers free confidential medical exam. The Young Adult Clinic is for Oak Cliff teenagers whose families receive AFDC. If you qualify, call the Young Adult Clinic in the A. Harris Center, 372-4671. Free medical help that's just for you.

FOR FURTHER INFORMATION, CONTACT

Gerald Jires, Coordinator
Young Adult Clinic
Texas Department of Public Welfare
372-4671 Ext. 273

Clinic: A. Harris Shopping Center
Health Dept. Offices
Dallas, Texas
372-4671

Office: [illegible]30-A Lancaster-Kiest Shopping Center
Dallas, Texas
372-4671 Ext. 273

Exhibit 6

CLIENT: YOUNG ADULT CLINIC

ANNOUNCER (60)

Most Young Adults have a lot of questions about how their bodies work. Questions about pregnancy- what part of the menstrual cycle is "safe"? How old do you have to be to get pregnant? Questions about VD--can a woman have it without knowing it? Can a man ? Where do you get the answers? Teenagers in South Oak Cliff whose families receive aid from the Texas Department of Public Welfare can go to the Young Adult Clinic in the A. Harris Shopping Center. The Young Adult Clinic can tell you everything you always wanted to know about you body. The Clinic provides free information and counseling, and a complete physical examination--also free. It's all confidential. For an appointment, call the Young Adult Clinic at 372-4671. The Young Adult Clinic, 372-4671, in the A. Harris Center a free service of the Texas Department of Public Welfare.

FOR FURTHER INFORMATION, CONTACT

Gerald Jines, Coordinator
Young Adult Clinic
Texas Department of Public Welfare
372-4671 Ext. 273

Clinic: A. Harris Shopping Center
Health Dept. Offices
Dallas, Texas
372-4671
Office: 230-A Lancaster-Kiest Shopping Center
Dallas, Texas
372-4671 Ext. 273

Exhibit 7

TDHR-DPW
Form 402-1
May 1976

EPSDT
EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT
MEDICAL REFERRAL

I. TO BE COMPLETED BY DPW OR CONTRACTING AGENCY

CASE INFO.

1. PATIENT'S DPW NO. ☐☐☐☐☐☐☐☐☐
2. CASE NAME (PAYEE)
3. REFERRAL NO.
4. PATIENT'S NAME (LAST, FIRST, MIDDLE)
5. BIRTH DATE ☐☐☐☐☐☐
6. ADDRESS (STREET, CITY, STATE, ZIP)
PHONE NO.
7. DPW WORKER/AGENCY REPRESENTATIVE
DPW WORKER BJN/ AGENCY NAME & ADDRESS
WORKER PHONE NO.

CLIENT INFO.

8. REFERRED TO (PHYSICIAN'S NAME, ADDRESS, ZIP):
PHYSICIAN PHONE NO.
9. APPOINTMENT TIME
DAY
DATE
10. RESCHEDULED APPOINTMENTS

II. TO BE COMPLETED BY SCREENING PROVIDER

PROVIDER INFORMATION AND TDHR CLINIC REPORT

1. TDHR PROVIDER NO. ☐☐☐☐☐

DEAR DOCTOR

THE ABOVE CHILD WAS SCREENED BY THE TEXAS DEPT. OF HEALTH RESOURCES ON AND A PROBLEM IS SUSPECTED AS SHOWN BELOW.

2. SCREEN DATE ☐☐☐☐☐☐
3. REASON FOR REFERRAL:
4. REFERRAL DATE ☐☐☐☐☐☐
5. PROBLEM HISTORY: ☐ COMPLETELY NEW CONDITION PREVIOUSLY KNOWN, ☐ NOT UNDER CARE ☐ UNDER CARE
6. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION ON THE ABOVE NAMED INDIVIDUAL TO THE TEXAS DEPARTMENT OF PUBLIC WELFARE AND THE TEXAS DEPARTMENT OF HEALTH RESOURCES.

SIGNATURE OF PARENT OR GUARDIAN
SIGNATURE DATE

III. TO BE COMPLETED BY PHYSICIAN (OR HIS STAFF) OR OTHER MEDICAL RESOURCE

PROVIDER REPORT TO DPW

1. SERVICE/EXAM DATE ☐☐☐☐☐☐
2. WAS INITIAL APPOINTMENT KEPT? ☐ YES ☐ NO*
NO. OF SCHEDULINGS BEFORE APPMT. KEPT? ____________
3. WAS SUSPECTED PROBLEM CONFIRMED AT THE DIAGNOSTIC/TREATMENT VISIT? ☐ YES ☐ NO
4. FOLLOW-UP CARE
☐ NO FURTHER TREATMENT NEEDED ☐ CONTINUED OFFICE CARE ☐ REFERRED TO ANOTHER MEDICAL RESOURCE (specify type, name, address) ⇨
5. IF FOLLOW-UP CARE IS REQUIRED, DO YOU NEED ASSISTANCE IN SUCH AREAS AS HELPING PATIENT KEEP APPOINTMENTS, SUPPORTING YOUR HOME TREATMENT REQUIREMENTS, ETC.?
☐ YES ☐ NO (explain, if yes)
6. PROBABLE DIAGNOSIS/ES OR IMPRESSION (OPTIONAL) – REMARKS:

* PLEASE NOTIFY WORKER (SECTION I, #7) FOR ASSISTANCE IF PATIENT FAILS TO KEEP APPOINTMENT.

PLEASE RETURN ALL COPIES IMMEDIATELY IN ATTACHED POSTAGE-FREE ENVELOPE. THANK YOU FOR YOUR COOPERATION.

Health Provider

TDHR-DPW
75 Form 402-S
May 1976

EPSDT MEDICAL REFERRAL SUPPLEMENT

III. FOR COMPLETION BY FOLLOW-UP WORKER

1. PATIENT'S DPW NUMBER ☐☐☐☐☐☐☐☐☐

2. PATIENT'S NAME (LAST, FIRST, MIDDLE)

3. REFERRAL NUMBER* ☐☐☐☐☐☐

4. EXAMINATION DATE ☐☐ ☐☐ ☐☐

5. WAS INITIAL APPOINTMENT KEPT? ☐ YES ☐ NO
NO. OF SCHEDULINGS BEFORE APPOINTMENT KEPT? ________

6. WAS SUSPECTED (REFERRED) PROBLEM CONFIRMED AT DIAGNOSTIC/TREATMENT VISIT? ☐ YES ☐ NO

7. FOLLOW-UP CARE:
☐ NO FURTHER TREATMENT NEEDED
☐ CONTINUED OFFICE CARE
☐ REFERRED ANOTHER MEDICAL RESOURCE ⇨ (specify type, name, address)

8. DOES PHYSICIAN REQUIRE ASSISTANCE FROM WORKER IN HELPING PATIENT KEEP APPOINTMENTS, SUPPORTING HOME TREATMENT PLANS, ETC.? ☐ YES ☐ NO

9. DIAGNOSIS:

10. SOURCE OF DOCUMENTATION: ☐ CLIENT ☐ PHYSICIAN ☐ OTHER

11. REASON FOR NON-COMPLETION OF REFERRAL-TREATMENT PROCESS:
☐ CLIENT REFUSAL
☐ SERVICE UNAVAILABLE
☐ OTHER
☐ CLIENT NOT LOCATABLE
} explain ➡
☐ CLIENT NO LONGER ELIGIBLE

12. DPW WORKER/AGENCY REPRESENTATIVE

DPW WORKER BJN/AGENCY NAME AND ADDRESS

SIGNATURE

DATE

* MUST CORRESPOND TO 402 REFERRAL NO. IN CASE RECORD, SECTION I, ITEM #3

HSRI

State of Texas
Department of Public Welfare

Form T-408
April 1976

EPSDT CASE MONITORING SHEET

1. Patient's DPW No.

2. Referral No.

3. Case Monitor Code

4. Name

Last First M.I.

5. Appointment Record

DATE	APPM'T. TIME	APPM'T. KEPT	COMMENTS

6. Narrative Summary of follow-up

7. **Problem Status (180 days after referral date or upon problem completion)**
   - a. Treatment completed, condition presumed cured or inactive after 1st visit .... 1☐
   - b. Treatment plan completed – now cured or inactive (follow-up contact).............................. 2☐
   - c. Treatment terminated – maximum benefit achieved (not necessarily inactive or cured).......... 3☐
   - d. Still under treatment (original practitioner/clinic).. 4☐
   - e. Still under treatment (referred practitioner/clinic)... 5☐

8. **Method of follow-up**
   - Mail.. 1☐
   - Phone.. 2☐
   - Personal contact .... 3☐
   - Other
     - Specify ____________________ 4☐

9. **Reasons for inability to complete problem**
   - Family moved.. 1☐
   - Family no longer eligible.................................. 2☐
   - Refuses to make another appmt. .... 3☐
   - Unable to contact after numerous efforts............. 4☐
   - Repeated appmt. failures.................................. 5☐
   - Other
     - Specify ____________________ 6☐

10. Date form completed

/ /
Mo. Day Yr.

HSRI

11. DPW Worker Signature

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